pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **NATIONAL HEALTH MANAGEMENT LLC**
LEGAL ENTITY

To operate **INDEPENDENCE COURT OF QUAKERTOWN**
NAME OF FACILITY OR AGENCY

Located at **1660 PARK AVENUE, QUAKERTOWN, PA 18951**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **120**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **August 20, 2025** until **February 20, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **127031**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 20, 2025

[redacted]
Manager
National Health Management, LLC
[redacted]

RE: Independence Court of Quakertown
1660 Park Avenue
Quakertown, Pennsylvania 18951
License #: 127031

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection April 17, 24, 25, and July 17, 2025 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 127030 dated July 22, 2025 to July 22, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from August 20, 2025 to February 20, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

Mr. Robert Petras

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *INDEPENDENCE COURT OF QUAKERTOWN* **License #:** *12703* **License Expiration:** *07/22/2025*

Address: *1660 PARK AVENUE, QUAKERTOWN, PA 18951*

County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *NATIONAL HEALTH MANAGEMENT LLC*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/13/1988* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *99* **Waking Staff:** *74*

Inspection Information

Type: *Partial* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Complaint, Incident* **Exit Conference Date:** *04/25/2025*

Inspection Dates and Department Representative

04/17/2025 - On-Site: [redacted]

04/24/2025 - On-Site: [redacted]

04/25/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served:** *74*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *25* **Are 60 Years of Age or Older:** *74*

Diagnosed with Mental Illness: *30* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *25* **Have Physical Disability:** *5*

Inspections / Reviews

04/17/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/02/2025*

06/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/15/2025*

06/20/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/02/2025*

07/30/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1's most recent assessment, dated [redacted], states that the resident requires one-to-one assistance with transferring into a wheelchair, and with bladder and bowel management. The support plan states that direct care staff "shall position rolling walker in front of wheelchair or recliner and assist resident to stand and pivot to transfer." Resident #1 also requires support with positioning pillows for turning/positioning in their new hospital bed. On [redacted], resident #1's assessment was updated, requiring direct care staff to provide two-person assistance as needed with transfers to and from resident #1's bed, commode, wheelchair, and recliner.

From 4/1-4/22/25, resident #1 waited for more than an hour for a response to their call bell on five occasions; the resident waited between forty minutes and one hour 16 times during this period. On 4/1/25 at 6:21 am, resident #1 used their call bell for assistance and waited one hour and two minutes for a response. On 4/20/25 at 7:16 am, resident #1 waited one hour and twenty-six minutes.

Resident #2 is incontinent of bladder and requires total physical assistance for toileting, bowel and bladder management. The resident also requires total physical assistance with mobility "due to blindness and weakness." Resident #2's support plan, dated [redacted] assigns the direct care staff "to assist with brief changes throughout the shift" and "assist with toileting relating to bowel." On 4/1/2025 at 10:35 am, resident #2 used the call bell station in their bathroom and waited one hour and three minutes for a response. Resident #2 used the same device on 4/7/25 at 9:11 am and waited 41 minutes and seven seconds; on 4/8/25 at 11:09am and waited 26 minutes and 14 seconds; and on 4/9/25 at 7:27 am, waiting 56 minutes and 36 seconds.

Resident #3's assessment and support plan received an update on [redacted] "related to a significant decline in ambulatory status." Resident #3 requires total physical assistance with transferring in and out of bed, personal hygiene, toileting, and bladder management, and some physical assistance with bowel management. Resident #3 used the call bell pendant on their bed on 4/23/25 at 7:54am and waited 37 minutes and 55 seconds for assistance, then at 11:58 am, waiting 23 minutes and 43 seconds. Resident #3 used the same device on 4/24/25 at 8:19 am and waited for 19 minutes and 46 seconds, then at 10:12 am, waiting seventeen minutes and 15 seconds.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
Resident 1's RASP was updated on 6/2/2025 by the Director of Nursing to reflect care needs.
Resident 2's RASP was updated on 4/22/2025 by the Director of Nursing to reflect care needs.
Resident 3's RASP was updated on 4/22/2025 by the Director of Nursing to reflect care needs.
Director of Nursing/Resident Care Coordinator to complete audit of all current resident RASP's to ensure documentation is stating what the resident needs are.
Training:
Education provided to all nursing staff regarding regulation 23(a) by Executive Director/Director of Nursing/Resident Care Coordinator by 6/30/2025.
On-going:
Beginning 6-2-25 the Director of Nursing/Resident Care Manager will monitor all new RASPs to ensure compliance with regulation 23(a).

23a - Activities of Daily Living Assistance (continued)

All ADL needs address and starting in June 2025 all new RASP will be discussed and reviewed at monthly 5 Quality assurance meeting with documentation kept.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented (- 07/30/2025)

42b - Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

From approximately late February to early April of 2025, staff person A repeatedly engaged in sexual activity, [redacted] resident #4 in the resident's room. The staff person, hired [redacted] became acquainted with the resident in the dining room. Staff person A would meet with the resident by descending a back staircase to avoid being seen entering the resident's room. Staff person A accepted approximately $500.00 from resident #4, apparently in exchange for sex, over a roughly month-long period from approximately 3/9/25 until the staff person's termination.

Staff made several complaints to management concerning staff person A socializing with residents and wearing provocative clothing. A supervisor observed staff person A leaving residents' rooms several hours after the staff person's shift had ended. In February 2025, the home transferred staff person A from the [redacted]tivities department.

Staff person A entered resident #5's room on the resident's birthday, ostensibly to ask why the resident had not gone to the dining room for lunch, and asked if the resident wanted [redacted] as a birthday present. When questioned by supervisors on [redacted] at approximately 2:00 pm, the staff person acknowledged having made such a comment and was suspended and then terminated.

Plan of Correction ***Accept (- 06/20/2025)***

Action:
Staff member A was suspended immediately on [redacted] by the Director of Nursing.
Then was terminated on [redacted] by the Executive Director.
Incident reported to the Department of Human Services on 4/9/2025 by the Director of Nursing.
Office of Aging was notified on 4/9/2025 by the Director of Nursing.
Local Police were notified on 4/9/2025 by the Director of Nursing.
Physician and family notified on 4/9/2025 by Director of Nursing.
Clinical leadership provided emotional support to residents #4 and #5 on 4/9 – 4/10/2025.
Training:
Education provided to the Director of Nursing/Resident Care Coordinator regarding regulation 42(b) on 5/29/2025 by the Executive Director. On 4/22/2025 and 4/23/2025 all staff training was conducted by [redacted] on abuse and neglect. On 6/1/2025 Community leadership has requested the Ombudsman provide onsite abuse and neglect training to all staff by the end of July 2025. Awaiting a date.

42b - Abuse (continued)

On-going:
Executive Director/Director of Nursing/Resident Care Coordinator to review during June staff meeting.
Someone from the Leadership team interviewed 3-4 residents/week x4 weeks, then monthly x2 months, then random interviews on-going with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented ([redacted] - 07/30/2025)

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Residents have suffered incontinence and bowel accidents as well long waits to be cleaned up due to the home's chronically insufficient staffing. In April, most shifts, (for example, 7:00 am-3:00 pm on 4/24/25) featured two caregivers and two med-techs (one on each floor), staffing a home with 74 residents, including 25 with mobility needs and several, such as resident #1, requiring two-person transfers.

Resident #2 is incontinent of bladder and requires total physical assistance for toileting, bowel and bladder management. The resident also requires total physical assistance with mobility "due to blindness and weakness." Resident #2's support plan, dated [redacted], assigns the direct care staff "to assist with brief changes throughout the shift" and "assist with toileting relating to bowel." On 4/1/2025 at 10:35 am, resident #2 used the call bell station in their bathroom and waited one hour and three minutes for a response. Resident #2 used the same device on 4/7/25 at 9:11 am and waited 41 minutes and seven seconds; on 4/8/25 at 11:09am and waited 26 minutes and 14 seconds; and on 4/9/25 at 7:27 am, waiting 56 minutes and 36 seconds.

Resident #3's assessment and support plan received an update on [redacted] "related to a significant decline in ambulatory status." Resident #3 requires total physical assistance with transferring in and out of bed, personal hygiene, toileting, and bladder management, and some physical assistance with bowel management. Resident #3 used the call bell pendant on their bed on 4/23/25 at 7:54am and waited 37 minutes and 55 seconds for assistance, then at 11:58 am, waiting 23 minutes and 43 seconds. Resident #3 used the same device on 4/24/25 at 8:19 am and waited for 19 minutes and 46 seconds, then at 10:12 am, waiting seventeen minutes and 15 seconds.

Resident #2 and #3 both acknowledged occasional toileting accidents while waiting for assistance. Day-shift staff report regularly finding several other residents in the morning lying in urine in their beds.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
On 4/25/2025 Staffing Agency, Shift Key, was contacted to assist with meeting resident needs.
On 4/28/2025 the call bell system was tested by the Maintenance Director to confirm working properly.
Training:
Education provided to the Director of Nursing/Resident Care Coordinator regarding regulation 42(b) on 5/29/2025 by the Executive Director.
On-going:
Executive Director/Director of Nursing/Resident Care Coordinator to review during June staff meeting.
Someone from the Leadership team interviewed 3-4 residents/week x4 weeks, then monthly x2 months, then

42b - Abuse (continued)

random interviews on-going with documentation kept and reviewed during QA beginning June 2025.

6/13/2025 Correction: AAA and [redacted] contacted 6/10/2025 to set up a date and time to come do a Direct Care Staff in-service on resident abuse. Awaiting response.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented ([redacted] - 07/30/2025)

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #6 was admitted to the home on [redacted] Resident #6's medication administration record (MAR) for April 2025 showed that the resident received zinc oxide 20% cream for rash, applied topically to sacral/buttock area twice daily throughout the month. On 4/1/25 at 8:30 am and on 4/25/25 at 8:30 am, staff person B signed as having administered the dose. Between these dates, each med-tech on duty indicated that they applied resident #6's cream in the morning or afternoon, including staff person C, whose initials appear on the MAR at 8:30 am and 4:30 pm on 4/24/25.

On 4/25/25, the resident complained to an agent of the Department of a painful skin condition on the buttocks. The resident said the skin condition had not been treated since admission, despite the resident's repeated requests to staff. One med-tech said that they were told that the caregiver on duty was applying the cream (direct care staff are not authorized to administer medications), while another assumed the resident was self-applying while in the bathroom. Resident #6 has PRN prescriptions for Baza antifungal 2 percent cream, Ketoconazole 2 percent cream, a Metronidazole topical .75 percent cream, and Nystatin 100,000 U/GM powder, all with instructions to apply topically twice a day as needed for rash. The MAR states that the resident "may keep at bedside and self-administer" these three creams and one powder, but resident #6 has been assessed not capable of self-administering medications. On 4/25/25, the Ketoconazole cream was not available in the home, while a 40 percent zinc oxide diaper rash cream, not listed in the resident's MAR, was in resident #6's room.

The Department did not find that the home provided treatment for resident #6's painful skin condition.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
The cream was removed from resident #6's room on 4/25/2025 by the Director of Nursing.
The Director of Nursing ordered Resident Ketocanazale cream on 4/28/2025 from the pharmacy.
Staff members B and C were removed from passing medication on 4/26/2025 by the Director of Nursing and staff members, B and C, will repeat the Medication administration course before allowing them to return to passing medications.
This will be completed by 6/15/2025. The Certified Train the Trainer will conduct MAR reviews and observations of all current Med Tech's by 6/30/2025.
Training:
Education provided to the Director of Nursing/Resident Care Coordinator regarding regulation 42(b) on 5/29/2025

42b - Abuse (continued)

by the Executive Director.
Director of Nursing/Resident Care Coordinator to re-educate all Med Tech's on medication administration and who is allowed to administer medication and/or apply creams by 6/30/2025
On-going:
Executive Director/Director of Nursing/Resident Care Coordinator to review during June staff meeting.
Someone from the Leadership team interviewed 3-4 residents/week x4 weeks, then monthly x2 months, then random interviews on-going with documentation kept and reviewed during QA beginning June 2025.

6/13/2025 Correction: resident #6's rash was checked by the physician and Resident Care Coordinator on 6/12/2025, rash has slightly improved, prescribed cream is being applied and documented as ordered by the Med Tech.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented (- 07/30/2025)

51 - Criminal Background Check

5. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

The home does not have a criminal background check for staff person B, hired , and for staff person D, hired

Plan of Correction ***Accept (- 06/20/2025)***

Action:
Employee B's criminal background check was located by the Executive Director on 5/29/2025. The background check was completed on .
Employee D's background check was located by the Executive Director on 5/29/2025. The background check was completed on
Administrative assistance completed an audit on 5/29/2025 of staff file to ensure all have a background check on file.
Training:
Education provided to all hiring managers on regulation 51 by the Executive Director on 5/29/2025.
On-going:
Beginning 5-29-25 The Executive Director or Administrative Assistant will review all new hire paperwork monthly and prior to employee training on the floor to ensure criminal background check is on file.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented (- 07/30/2025)

54a - Direct Care Staff

6. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:

54a - Direct Care Staff *(continued)*

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff persons B and D do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
Staff member B's Highschool Diploma/GED was located by the Executive Director on 5/29/2025.
Staff member D's Highschool Diploma/GED was located by the Executive Director on 5/29/2025. Administrative Assistant audited all current staff on 5/29/2025 to ensure all have a high school diploma on file.
Training:
Education provided to all hiring managers on regulation 54(a) by the Executive Director on 5/29/2025.
On-going:
The Executive Director or Administrative Assistant will review all new hire paperwork prior to starting employment to ensure have a copy of high school diploma with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented ([redacted] - 07/30/2025)

57c - 2 Hours/Day

7. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 3/22/2025, there were 78 residents in the home, including 25 residents with mobility needs, requiring a total minimum of 103 hours of direct care service. On this date, only 97.75 hours of direct care staffing were provided.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
Staffing Agency, Shift Key, was brought in on 4/25/2025 to ensure community staffing is meeting regulation 57c by the Executive Director.
Training:
Education provided to the Director of Nursing/Resident Care Coordinator regarding regulation 57(c) on 5/29/2025 by the Executive Director.
On-going:
The Executive Director and Director of Nursing will monitor staffing hours daily to ensure the community is staffed appropriately with documentation kept and reviewed in QA beginning in June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented ([redacted] - 07/30/2025)

57d - Waking Hours

8. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 3/22/2025, a total of 103 hours of direct care was required. However, only 75.25 of the required hours, or 73 percent, were provided during waking hours.

Plan of Correction ***Accept (- 06/20/2025)***

Action:
Staffing Agency, Shift Key, was brought in 4/25/2025 to assist with meeting resident needs by the Executive Director.
Training:
Education provided to Director of Nursing/Resident Care Coordinator regarding regulation 57(d) on 5/29/2025 by the Executive Director.
On-going:
The Executive Director will monitor staffing hours daily to ensure the community is staffed appropriately to meet the resident's needs with documentation kept and reviewed during QA beginning June 2025

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented (- 07/30/2025)

60a - Staff/Support Plan

9. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Resident #1's assessment and support plan, dated , was updated on requiring direct care staff to provide two-person assistance as needed with transfers to and from resident #1's hospital bed, commode, wheelchair, and recliner. On 4/24/2025, the resident did not receive this assistance as required. Staff person E was the only aide assigned to the first floor, where resident #1 resides in from 7:00am-3:00pm. Resident #1 used their call bell pendant at 9:26 am on 4/24/25 and waited 16 minutes and 53 seconds for assistance.

In April 2025, most shifts (for example, 7:00am-3:00pm on 4/24/25) featured two caregivers and two med-techs (one on each floor), staffing a home with 74 residents (on 4/25/25), including 25 with mobility needs and several, such as resident #1, requiring two-person transfers.

60a - Staff/Support Plan (continued)

Plan of Correction ***Accept (- 06/20/2025)***

Action:
Staffing Agency, Shift Key, was brought in on 4/25/2025 to assist with meeting resident needs.
Training:
Education provided to Director of Nursing/Resident Care Coordinator regarding regulation 60(a) on 5/29/2025 by the Executive Director.
On-going:
The Executive Director will monitor staffing hours daily to ensure the community is staffed appropriately to meet residents' needs and reviewed during monthly quality assurance meeting beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented (- 07/30/2025)

63a - First Aid/CPR Training

10. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

There were zero staff persons present in the home who were certified in First Aid/CPR during the following time periods:

- *11:00 pm on 4/4/2025 to 6:45 am on 4/5/25*
- *11:00 pm on 4/18/25 to 7:00 am 4/19/25*
- *11:00 pm on 4/19/25 to 7:00 am on 4/20/25*

There was only one staff person present in the home who was certified in First Aid/CPR during the following time periods, while more than 50 residents were in the home:

- *3:00 pm on 4/20/25 to 6:45 am on 4/21/25*
- *3:00 pm to 10:45 pm on 4/23/25*

Plan of Correction ***Accept (- 06/20/2025)***

Action:
CPR/First aid class scheduled for 6/6/2025.
Administrative Assistant to complete an all-employee audit, ensuring that all employees are CPR/First aid certified by 6/30/2025.
Training:
Education provided to the Director of Nursing/Resident Care Coordinator regarding regulation 63(a) on 5/29/2025 by the Executive Director.
On-going:
Executive Director or Administrative Assistant will monitor monthly community compliance with regulation 63(a) with the use of staff training tickler reviewed in QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

63a - First Aid/CPR Training *(continued)*

Implemented (- 07/30/2025)

65d - Initial Direct Care Training

11. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B was hired on Direct care staff person E was hired on and began performing direct care services on Direct care staff person F was hired on and began performing direct care services on

As of 4/25/2025, staff persons B, E, and F did not complete the Department-approved direct care training course and competency test.

Plan of Correction ***Accept (- 06/20/2025)***

Action:
Staff member B's Director Care Training certification was located on 5/29/2025 by the Executive Director. Training was completed on 6/9/2023.
Staff member E's Director Care Training certification was located on 5/29/2025 by the Executive Director. Training was completed on 7/12/2024.
Staff member F's Director Care Training certification was located on 5/29/2025 by the Executive Director. Training was completed on 4/26/2023.
Administrative Assistant to complete an all-employee audit, ensuring that all required employees have completed the Direct Care Training by 6/30/2025.
Training:
Education provided to all hiring managers on regulation 65(d) by the Executive Director on 5/29/2025.
On-going:
Executive Director or Administrative Assistant will review all new hire paperwork prior to employee training on the floor to ensure that all required paperwork is present with documentation kept and reviewed during QA monthly beginning June 2025.
Direct Care Training certificates will be housed in the employee's file.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented (- 07/30/2025)

85a - Sanitary Conditions

12. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/25/2025 at approximately 12:00 pm

85a - Sanitary Conditions (continued)

, there was a spill of liquid-thickener in the refrigerator in the first-floor med room.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
Medication Refrigerator was cleaned by the Med Tech on 4/25/2025.
Training:
Education to all staff regarding regulation 85(a) by the Executive Director/Director of Nursing/Resident Care Coordinator completed by 6/30/2025.
On-going:
Member of the Leadership team or housekeeping will walk the community to ensure all sanitary conditions maintained with documentation kept and reviewed during QA beginning June 2025.

6/13/2025 Correction: Member of Leadership Team or housekeeping will complete walkthroughs of the community at least daily with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented ([redacted] - 07/30/2025)

87 - Lighting

13. Requirements

2600.
87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On 4/17/2025 at 9:36 am, the ceiling of the first-floor hallway between resident rooms had a recess light that was not working and the recess light next to it was flickering on and off.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
Light on first floor malfunctioning was replaced on 4/17/2025 by Maintenance Director.
Training:
Education to all staff regarding regulation 87 by the Executive Director/Director of Nursing/Resident Care Coordinator to be completed by 6/30/2025.
On-going:
A Member of the Leadership team will walk the community at least daily to ensure that lighting is in good working order with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented ([redacted] - 07/30/2025)

121a - Unobstructed Egress

14. Requirements

2600.

121a - Unobstructed Egress *(continued)*

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 4/17/2025 at approximately 9:15 am, there were three black trash bags and a hand cart blocking the rear egress from the home's kitchen.

Plan of Correction ***Accept (- 06/20/2025)***

Action:
Trash bags and cart removed immediately on 4-17-25 by dietary staff.
Training:
Education to all staff regarding regulation 121(a) beginning 5/29/2025 by the Executive Director/Director of Nursing/Resident Care Manager.
On-going:
Member of the Leadership team will walk community daily to ensure all egresses are unobstructed with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented (- 07/30/2025)

161d - Dietary Needs

15. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

Resident #6's Documentation of Medical Evaluation, completed , states that the resident requires a heart-healthy diet with no concentrated sweets. The kitchen wall has an area featuring the pictures and dietary requirements of residents with special diets for the dietary staff's reference, but on 4/25/2025 resident #6 was not included.

Plan of Correction ***Accept (- 06/20/2025)***

Action:
Resident #6's information was posted in the kitchen by Director of Nursing on 6/2/2025.
Director of Nursing/Resident Care Coordinator to complete an all-resident audit by 6/30/2025 on diet orders and those with special diet are captured on the kitchen diet board.
Training:
Executive Director re-educated Director of Nursing/Resident Care Coordinator/Dining Director on regulation 161(d) on 5/9/2025.
On-going:
Director of Nursing/Resident Care Coordinator/Dining Director to complete weekly monitoring of residents dietary needs to ensure compliance with regulation 161(d) with documentation kept and reviewed during QA beginning June 2025.

161d - Dietary Needs *(continued)*

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented ([redacted] - 07/30/2025)

181c - Self-administration Assessment

16. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #7 is prescribed one 75-mcg Levothyroxine tablet every morning. The resident has self-administered this medication every morning at 6:00 am from 4/1 to 4/25/2025. However, resident #7's Documentation of Medical Evaluation, completed [redacted], indicates the resident is not able to self-administer medications.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
Medication removed from room on 4/17/2025 by Med Tech and placed in medication cart.
Director of Nursing/Resident Care Coordinator will complete an all-resident audit of DME's and physician orders for all residents who self-administer medication by 6/30/2025.
Training:
Education provided to the Director of Nursing/Resident Care Coordinator regarding regulation 181(c) by the Executive Director. Education will provide to all Med Techs by the Executive Director/Director of Nursing/Resident Care Coordinator by 6/15/2025.
On-going:
Director of Nursing/Resident Care Coordinator will review all new residents who want to self-administer to ensure they can safely self-administer and that have order to self-medicate from physician.
Director of Nursing/Resident Care Coordinator to complete self-administer observations quarterly with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented ([redacted] - 07/30/2025)

182b - Prescription Medication

17. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.

182b - Prescription Medication *(continued)*

4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Resident #8 is prescribed one 100-MG Docusate Sodium capsule every morning and one drop in each eye of Latanoprost PF Opthalmic Solution before bedtime. Resident #8's [redacted] resident #7, has been administering these medications from 4/1 to 4/24/25 every day at 8:30 am and 8:30 pm, respectively. Resident #7 is not qualified to administer medications to residents in the home. Residents #7 and #8 are both assessed as unable to self-administer medications.

Staff person G's initial medication administration training was completed on a paper form on 9/4/24, after the 1/1/24 deadline for the initial training to be completed electronically. Staff person G administered a 100-MG Allopurinol tablet to resident #9 on 4/15/25 at approximately 8:30 am.

Staff person E is missing the "Trainer attestation of qualification" for their initial medication administration training. Staff person E administered a 100-MG Allopurinol tablet to resident #9 on 4/3/25 at approximately 8:30 am.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
Eye drops removed from resident #8's room on 4/24/2025 by Med Tech and placed in medication cart.
Staff G and E were removed from passing medications immediately on 4/24/2025.
Training:
All employees will be trained in regulation 182(b) by the Executive Director/Director of Nursing/Resident Care Coordinator by 6/30/2025.
Education will be provided to Director of Nursing/Resident Care Coordinator regarding regulation 182(b) by the Executive Director by 5/29/2025.
On-going:
Beginning 6/2/2025, the Executive Director or a member of clinical leadership will review all new med tech certification to ensure they meet requirement of 182(b) with documentation kept and reviewed during QA beginning in June 2025.

Correction 6/13/2025: Staff member E's employment was terminated on [redacted] due to no call/no show for [redacted] shift. Staff member G was re-trained on medication administration on 5/29/2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented ([redacted] - 07/30/2025)

183b - Meds and Syringes Locked

18. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 4/24/2025, from 9:35-9:45 am, staff person C went to room 135 to administer medications in a resident's

183b - Meds and Syringes Locked (continued)

bedroom, leaving the medications in the first-floor med room unattended. The door to the room and the two medication carts inside were left unlocked.

At 10:05 am, staff person G left the med room on the second floor, with medications inside, unlocked and unattended for more than five minutes while getting ice from the dining room.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
Staff member C was pulled from medication cart on 4/25/2025 by the Director of Nursing and put through the Med Tech class by the Director of Nursing who is an approved trainer. Unlocked medication cart was locked on 4/25/2025 by the Director of Nursing and delivered verbal counseling to staff member G on 4/25/2025
Training:
Director of Nursing/Resident Care Coordinator will re-educate current nurses and Med Tech's on regulation 183(b) by 6/30/2025.
On-going:
Beginning 5-29-25, the
Member of the leadership team will complete daily rounds to ensure compliance with Regulation 183(b) with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented ([redacted] - 07/30/2025)

183d - Prescription Current

19. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 4/25/2025, a sleeve of 600-MG Mucus Relief ER tablets prescribed for resident #8 were in the home's medication cart; however, the medication was discontinued on 3/28/25.

The cart also contained a wound wash saline spray. The spray was labeled for resident #9 but does not appear on the resident's current medication orders or medication administration record.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
Med Tech removed discontinued medication on 4/17/2025 of resident #8 and #9 from the med cart.
Clinical leadership audited all current residents' medication to ensure all discontinued medications removed from cart on 5/20/2025.
Training:
Executive Director/Director of Nursing/Resident Care Coordinator will re-educate nurses and Med Tech's on regulation 183(d) by 6/15/2025
On-going:
Clinical leadership will complete weekly medication cart audits with documentation kept and reviewed during QA beginning June 2025.

183d - Prescription Current *(continued)*

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented ([redacted] - 07/30/2025)

183e - Storing Medications

20. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 4/24/2025 at approximately 10:20 am, there was a loose syringe on a second-floor med cart among the medications for resident #10. At 10:23 am, there were loose pills in cart #2 on the second floor. A sleeve containing resident #11's .5-MG Lorazapam tablets was punctured in the back, exposing the dose marked #4. Cart #1 contained three narcotics which had all expired on 3/31/25: Tramadol belonging to resident #12, and Lorazepam for residents #13 and #14.

On 4/25/25, a container of Dorzolamide-Timolol Eye Drops was on the medication cart for resident #15. The date written on the bottle indicated that it was opened on 3/17/2025. According to the manufacturer's instructions, the product should be discarded within 28 days of opening (by 4/14/25).

Plan of Correction Repeated Violation: 12/11/24 et al. ***Accept ([redacted] - 06/20/2025)***

Action:
On 4/24/2025 Med Tech on duty removed the loose pills from medication carts on 2nd floor.
On 4/24/2025 the Director of Nursing removed expired narcotic medications for residents #12, #13, and #14. Medications were destroyed by Med Tech on 4/24/2025 as well as resident #10's lorazepam that was punctured.
On 4/25/2025 Med Tech on duty discarded resident #10's expired eye drops and reordered a new bottle from the pharmacy.
On 5/13 – 5/14/2025 Clinical leadership audited all current residents' medication to ensure compliance with regulation 183(e).
Training:
Executive Director educated Director of Nursing/Resident Care Coordinator on regulation 183(e) on 5/29/2025.
Director of Nursing/Resident Care Coordinator will re-educate all current Med Tech's on regulation 183(e) by 6/30/2025.
On-going:
The Director of Nursing/Resident Care Coordinator or a member of Clinical leadership will complete weekly cart audits with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented ([redacted] - 07/30/2025)

184b - Labeling OTC/CAM

21. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

184b - Labeling OTC/CAM *(continued)*

Description of Violation

On 4/25/2025, a package of 40 percent zinc oxide diaper rash cream belonging to resident #6 was in a medication cart and was not labeled with the resident's name or room number.

Plan of Correction Repeated Violation: 12/11/24 et al. ***Accept (- 06/20/2025)***

Action:
Med Tech removed cream from room immediately on 4/17/2025 and put in medication cart.
Director of Nursing/Resident Care Coordinator to complete medication cart audits on all medication carts by 6/30/2025.
Training:
Director of Nursing/Resident Care Coordinator/Med Tech's will be trained on regulation 184(b) by the Executive Director by 6/30/2025.
On-going:
The Director of Nursing or Resident Care Coordinator will complete weekly medication cart audits starting June 2025 x3 months then monthly x2 months with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented (- 07/30/2025)

185a - Implement Storage Procedures

22. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #6 is prescribed Ketoconazole 2 percent cream and .3mg Nitroglycerin tablets as needed. On 4/25/25, these medications were not available in the home.

Resident #7 is prescribed Formula DC 303 tablets as needed. On 4/25/25, this medication was not available in the home.

On 4/14/2025, resident #8 requested a dose of APAP as needed for pain, but the medication was not administered because the resident's 325-MG tablets were not available in the home. The medication was also not in the home on 4/25/25.

Plan of Correction ***Accept (- 06/20/2025)***

Action:
Medications for residents #6, #7, and #8 were ordered from the pharmacy by the Director of Nursing on 4/25/2025.
Training:
The Director of Nursing/Resident Care Coordinator/Med Techs will be educated on regulation 185(a) by the Executive Director by 6/30/2025.
Ongoing:

185a - Implement Storage Procedures (continued)

The Director of Nursing or Resident Care Coordinator will complete weekly cart audits with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented (- 07/30/2025)

[redacted]

WITHDRAWN: 8/13/25

[redacted]

187b - Date/Time of Medication Admin.

24. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #9 is prescribed a 50-MCG Levothyroxine tablet every morning. Resident #9's medication administration record does not include the initials of the staff person who administered this medication, if it was administered, on 4/10/2025 at 6:00 am. Repeat Violation: 7/1/24

Plan of Correction ***Accept (- 06/20/2025)***

Action:

187b - Date/Time of Medication Admin. (continued)

Resident #9's PCP was notified on 4/28/2025 that Levothyroxine was missed on 4/10/2025.
Audit of all current residents' medication record will be completed by the Director of Nursing by 6/16/2025.
Training:
Executive Director/Director of Nursing/Resident Care Coordinator re-educated all Med Tech's on regulation 187(b).
On-going:
Director of Nursing/Resident Care Coordinator/Member of Clinical leadership will monitor current residents' medication records 3x/week x2 months then weekly x2 months to ensure all medication is compliant with regulation 187(b) with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented ([redacted] - 07/30/2025)

187d - Follow Prescriber's Orders

25. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #6 is prescribed a Humalog Kwikpen 100U/ML three times daily before meals. On 4/21/2025 at approximately 12:30pm, staff person C mistakenly injected the resident with Lantis Solostar 100 Units/M, which the resident is prescribed to take at bedtime. From 4/1-4/25/25, resident #6 did not receive zinc oxide 20% cream for rash, prescribed topically to sacral/buttock area twice daily.

Resident #9 is prescribed a 50-MCG Levothyroxine tablet every morning. However, this medication was not administered to resident #9 on 4/16/25 at 6:00 am because the medication was not available in the home.

Resident #15 is prescribed one 50-MG tablet of Atenolol every evening. However, this medication was not administered to resident #15 on 4/6/2025 at 7:00 pm because the medication was not available in the home.

Plan of Correction Repeat Violation: 7/1/24 ***Accept ([redacted] - 06/20/2025)***

Action:
On 4/28/2025 Director of Nursing notified the following resident PCP's regarding ….
Resident #6 receiving the wrong insulin on 4/21/2025 and not receiving the application of Zinc Oxide from 4/1 – 4/4/2025.
Resident #9 missed dose of Levothyroxine on 4/16/2025.
Resident #15 missed dose of Atenolol on 4/6/2025.
Director of Nursing/Resident Care Coordinator to complete an all-resident audit of medication records by 6/6/2025.
Training:
Executive Director/Director of Nursing/Resident Care Coordinator will re-educate all Med Tech's on regulation 187(d) by 6/30/2025.
On-going:
Director of Nursing/Resident Care Coordinator/Clinical leadership will monitor current resident medication record 3x/week for 2 months then weekly x2 months with documentation kept and reviewed during QA beginning June 2025.

187d - Follow Prescriber's Orders *(continued)*

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented ([redacted] - 07/30/2025)

190a - Completion Medication Course

26. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person F did not successfully completed the Department-approved medications administration course until 4/25/2025. Staff person F administered 50-MG tablets of Atenolol to resident #16 at 7:00 pm on 4/8, 4/12, and 4/15/2025.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
Director of Nursing, who is a Certified Med Tech trainer, audited all current Med Tech files on 4/21/2025 to ensure all have documentation of passing medication course by 4/28 – 4/29/2025.
Training:
Executive Director re-educated Director of Nursing/Resident Care Coordinator on Regulation 190(a) on 5/29/2025.
On-going:
Executive Director or Director of Nursing will confirm all new Med Tech's have passed the approved medication course with documentation kept.
Executive Director/Administrative Assistant will review new hire Med Tech paperwork to ensure all required documents are in hand with documentation kept and reviewed in QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented ([redacted] - 07/30/2025)

190b - Insulin Injections

27. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 4/12/2025 at 4:30 pm, staff person F, who has not completed a Department-approved diabetes patient education program within the past 12 months, administered insulin to resident #6.

Plan of Correction ***Accept ([redacted] - 06/20/2025)***

Action:
Staff member F was removed from passing medications on 4/26/2025 until the approved diabetic training course has been completed successfully.

190b - Insulin Injections (continued)

Diabetic training is scheduled for 6/30/2025.
Director of Nursing/Resident Care Coordinator completed an audit of all Med Tech's on 4/30/2025 to ensure they all have an up-to-date diabetic training.
Training:
Acting Executive Director re-educated Director of Nursing/Resident Care Coordinator on regulation 190(b) on 5/29/2025.
On-going:
A member of the Clinical leadership team/Administrative Assistant will review all Med Tech diabetic training dates to ensure compliance monthly beginning June 2025 with documentation kept and review during QA beginning June 2025

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented (- 07/30/2025)

225a - Assessment 15 Days

28. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident #8, who was admitted to the home on

Plan of Correction ***Accept (- 06/20/2025)***

Action:
Director of Nursing to complete resident #8's RASP by 6/6/2025.
Director of Nursing/Resident Care Coordinator will complete an all-resident audit to ensure that all residents have RASP's by 6/30/2025.
Training:
Executive Director educated Director of Nursing/Resident Care Coordinator on regulation 225(a) on 5/29/2025.
On-going:
Director of Nursing/Resident Care Coordinator will audit new admission RASP to ensure that it's completed timely per regulation with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented (- 07/30/2025)

225c - Additional Assessment

29. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

225c - Additional Assessment *(continued)*

Description of Violation

Resident #1's most recent assessment was completed on [redacted]

Plan of Correction ***Accept (- 06/10/2025)***

Action:
Director of Nursing will complete a new RASP by 6/25/2025 on Resident #1.
An audit of current residents RASP will be completed by a member of leadership to ensure all are done on an annual basis and will create a tickler by 6/30/2025 so know when annual due moving forward.
Training:
Executive Director educated Director of Nursing/Resident Care Coordinator on 5/29/2025 on Regulation 225(c).
On-going:
Director of Nursing/Executive Director will review RASP tickler monthly to ensure RASP are completed annually with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/02/2025*

Not Implemented (- 07/30/2025)

227g -Support Plan Signatures

30. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3's support plan was completed on [redacted] *However, the resident did not sign the support plan and there was no indication of whether the resident refused or was unable to sign.*

Plan of Correction Repeated Violation: 12/11/24 et al. ***Accept (- 06/20/2025)***

Action:
Resident #1's RASP was obtained by Director of Nursing on 6/2/2025.
An audit of all current resident RASP will be done by a member of leadership to ensure each RAS has appropriate signatures by 6/30/2025.
Training:
Executive Director educated Director of Nursing/Resident Care Coordinator on regulation 227(g) on 5/29/2025.
On-going:
Executive Director/Director of Nurse/Resident Care Coordinator will monitor all new RASP monthly to ensure all appropriate signatures are in place with documentation kept and reviewed during QA beginning June 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented (- 07/30/2025)

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *INDEPENDENCE COURT OF QUAKERTOWN* **License #:** *12703* **License Expiration:** *07/22/2026*

Address: *1660 PARK AVENUE, QUAKERTOWN, PA 18951*

County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

[redacted]

Name: *NATIONAL HEALTH MANAGEMENT LLC*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/13/1988* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *104* **Waking Staff:** *78*

Inspection Information

Type: *Partial* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Monitoring* **Exit Conference Date:** *07/17/2025*

Inspection Dates and Department Representative

07/17/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served:** *69*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *69*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *35* **Have Physical Disability:** *0*

Inspections / Reviews

07/17/2025 - Partial

Lead Inspector [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/09/2025*

Inspections / Reviews *(continued)*

08/13/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/07/2025*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

08/13/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *08/13/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

62 - Contact List

1. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

[redacted] *the administrator, could not provide a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.*

Plan of Correction ***Accept ([redacted] - 08/08/2025)***

Please see attached. To ensure compliance with accurate and up-to-date employee contact information, the Administrator, and/or Business Office Manager/HR will be responsible for maintaining a current list of names, addresses, and telephone numbers. The list will be reviewed and updated routinely and upon any staff changes such as new employees joining our team or changes in current employee status. It will be the responsibility of each employee to keep HR informed of all changes in their names, addresses, and telephone numbers. Staff will be reminded of this regulation at the mandatory all staff meeting on 8/7/25. This process will ensure records remain current and readily accessible for regulatory and operational needs.

Licensee's Proposed Overall Completion Date: *08/06/2025*

Not Implemented ([redacted] - 08/13/2025)

181c - Self-administration Assessment

2. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1 self-administers medications to include Zinc Oxide Ointment 20%; however, resident #1 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept ([redacted] - 08/08/2025)***

It was identified that resident #1 was accessed by the Director of Wellness as safe to self-administer a prescribed ointment. The ointment had been removed from the resident's possession until a new physician's order and updated DME are received pending further clarification. Once the order is received, the resident's RASP will be updated to reflect the ointment, self-administration status, and confirmation of safety. The DOW will then be responsible for reviewing and revalidating the resident's ability to self-administer. The self-administration evaluation will be conducted quarterly and documented in our PCC program. The DOW has reviewed all residents who self-administer {completed 8/5/25} and will continue to do so quarterly as prompted by our program. DOW and /or RCC and will be responsible to maintain safety and compliance with this regulation going forward.

Licensee's Proposed Overall Completion Date: *08/06/2025*

181c - Self-administration Assessment *(continued)*

Not Implemented (- 08/13/2025)

182b - Prescription Medication

3. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Resident #2 is prescribed Latanoprost PF Ophthalmic Solution - one drop in each eye at bedtime for glaucoma. Resident #2's Resident #3, has been administering these medications from 7/1/25 to 7/16/25 every night. Resident #3 is not qualified to administer medications to residents in the home.

Plan of Correction ***Accept (- 08/08/2025)***

Resident #3 stated that believed was permitted to do so as considers the community home and was acting as did in own home prior to moving into the personal care home. Upon review, it was confirmed that there is a current physician's order for the eye drops, and the task is outlined in the resident's RASP. The resident has been re-educated on community and regulatory policies. The medication was removed on 7/18/25 and staff will monitor and document medication administration to ensure compliance and prevent recurrence. Moving forward, residents upon admission who have physician ordered medications or treatments listed on their DME and are capable of self -administration will be assessed by the Director of Wellness and on a quarterly basis. this will be documented in our PCC program.

Licensee's Proposed Overall Completion Date: *08/06/2025*

Not Implemented (- 08/13/2025)

184b - Labeling OTC/CAM

4. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 7/17/25, a package of Ammonium Lactate 12% belonging to resident #4 was in the medication cart and was not labeled with the resident's name.

Repeat Violation Date: 12/11/24 et al

184b - Labeling OTC/CAM *(continued)*

Plan of Correction ***Accept ([redacted] - 08/08/2025)***

The cited violation is noted as a repeat violation, however the date referenced occurred prior to the transition of community ownership and management under the new company. {7/1/25} The medication was labeled while surveyors were present. To ensure compliance with mediation storage and labeling regulations, the new pharmacy provider conducted a full audit. This audit included all prescription medications and over-the-counter products. The audit was completed on 8/4/25. All OTC's were checked for expiration dates and proper labeling. Going forward, Medication technicians will do a cart audit after each medication pass. Any items not in compliance will be corrected, relabeled, or removed as appropriate. The new pharmacy provider will conduct monthly audits at the end of each month during the routine medication transition process. Residents and family members had been reminded of this regulation on 8/5/25 at the Monthly Resident Council Meeting---documented in minutes. Family and/or responsible parties were notified via mail in a letter dated and sent out on 8/6/25 of this regulation. The DOW or RCC will be the person responsible for conducting routine audits to ensure no repeats in this area.

Licensee's Proposed Overall Completion Date: *08/06/2025*

Not Implemented ([redacted] - 08/13/2025)

185a - Implement Storage Procedures

5. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1 is prescribed: Baza Antifungal 2% cream- apply topically to affected area twice daily as needed for rash, Ketoconazole 2% cream- apply topically to affected area twice daily as needed for fungal rash, Metronidazole Top 0.75% cream- apply topically to affected area twice daily as needed for dermatitis and Nystatin 100,000 U/GM Powder- apply topically to groin and buttocks twice daily as needed for fungal rash. On 7/17/25, these medications were not available in the home.

Resident #3 is prescribed Docusate Sodium 100mg- 1 capsule twice daily as needed. On 7/17/25, this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 08/08/2025)***

Upon audit, it was identified that some residents did not have their prescribed PRN medications and topical creams available at the time of need. The Director of Wellness took immediate corrective action and promptly ordered all missing medications and creams on the same day as the inspection. {7/17/25} A thorough medication cart audit was performed. We were in a transition with our pharmacy provider. To prevent recurrence, our new pharmacy provider will maintain stock availability of all commonly used PRN medications and topical creams. These products will be checked monthly with our end-of-month medication run. Moving forward, each medication technician will do a cart audit while doing the med pass prior to the next medication technician taking over the cart. Medication will be ordered as necessary to avoid not having it. A weekly cart audit will be performed by the DOW or RCC and medications to ensure compliance and inventory readiness. This will be ongoing, and DOW will be responsible for

185a - Implement Storage Procedures (continued)

ensuring medications prescribed are always available.

Licensee's Proposed Overall Completion Date: *08/07/2025*

Not Implemented (- 08/13/2025)

227g -Support Plan Signatures

6. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #5 participated in the development of support plan on ; however, the resident did not date the support plan.

Resident #6 participated in the development of support plan on however, the resident did not date the support plan.

Resident #7 participated in the development of support plan on ; however, the resident did not sign the support plan.

Repeat Violation Date: 12/11/24 et al

Plan of Correction ***Accept (- 08/08/2025)***

The cited violation is noted as a repeat violation, however the dates referenced occurred prior to the transition of community ownership and management under the new company. Since the transition {7/1/25} the newly appointed Director of Wellness has conducted a comprehensive review of all support plans. Each resident's support plan was reviewed, and either signed and/or dated by the resident or responsible party. Residents #5, 6, and 7 all dated accordingly. On 8/4/25, all support plans were completed by the RCC. Going forward, the Director of Wellness will obtain signatures and dates as completed and reviewed with the resident and/or responsible party to ensure continued compliance and accuracy. New management is fully aware of the regulations and is committed to preventing repeat violations. It will be the ongoing responsibility of the DOW to obtain signatures and dates. The Administrator will spot check to ensure regulatory compliance.

Licensee's Proposed Overall Completion Date: *08/06/2025*

Not Implemented (- 08/13/2025)