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

August 13, 2025

[redacted], REGIONAL DIRECTOR OF OPERATIONS
BALA CYNWYD OPERATING LP
[redacted]

RE: SYMPHONY SQUARE AT BALA CYNWYD
35 OLD LANCASTER ROAD
BALA CYNWYD, PA, 19004
LICENSE/COC#: 14776

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/21/2025, 04/22/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SYMPHONY SQUARE AT BALA CYNWYD* **License #**: *14776* **License Expiration**: *05/01/2025*

Address: *35 OLD LANCASTER ROAD, BALA CYNWYD, PA 19004*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *BALA CYNWYD OPERATING LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *02/24/2012* **Issued By**: *Lower Merrion Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *67* **Waking Staff**: *50*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/22/2025*

Inspection Dates and Department Representative

04/21/2025 - On-Site: [redacted]

04/22/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *44*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Connections* **Capacity**: *16* **Residents Served**: *10*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *44*

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

Have Mobility Need: *23* **Have Physical Disability**: *2*

Inspections / Reviews

04/21/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/22/2025*

05/30/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/20/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/04/2025*

Inspections / Reviews *(continued)*

06/02/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/20/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/22/2025*

08/13/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/20/2025*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 04/21/2025 at 09:44 AM, the assignment sheets for the home's secured dementia care unit (SDCU) were unlocked, unattended, and accessible to anybody on the countertop of the medication room. The assignment sheets include each resident's incontinence assistance required, mobility needs, mobility devices utilized, and the level of assistance needed for activities of daily living.

Plan of Correction ***Accept (- 06/02/2025)***

Assignment sheets located in the Memory support care station were immediately removed on 4/21/25.
4/24/25- Director of Health and Wellness (DHW) completed community wide audit of care stations to ensure resident personal information is locked and inaccessible when unattended.
June 11, 2025 Clinical associates to be re-trained by Executive Director (ED) that assignment sheets must be in a location that is locked and inaccessible when unattended.
June 12- Ongoing, DHW or designee, will complete weekly audits x 4 weeks and monthly audits for 2 months to ensure that assignment sheets are locked and inaccessible when unattended.
The Executive Director (ED) will review audits to determine if any further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented (- 08/13/2025)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated , for resident #1 was not signed by the resident.

Repeat Violation: 07/15/2024 et al.

Plan of Correction ***Accept (- 06/02/2025)***

Resident #1 signed the agreement on 4/21/25.
4/23/25- Executive Director re-train Sales Director and Director of Business Administration that all residents must sign agreement or follow RCG guidelines if resident refuses.
6/3/25- Executive Director completed community wide audit to ensure that contracts were signed by residents.
July 2025- To assist with ongoing compliance Sales Manager or designee, will complete monthly audits x 3 month of new resident agreements to ensure resident signed agreement.
Executive Director will review the results of audits to determine if any further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

25b - Contract Signatures *(continued)*

Implemented (- 08/13/2025)

42s - Privacy

3. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On in the morning, resident #2 returned to the home from stay at a hospital. The resident found the apartment in a mess, with important documents that were placed on top of the table and kitchenette lying around on the floor. When the resident complained about this, staff A admitted entering the room and moving things around without any legitimate reasons/explanations.

Plan of Correction ***Accept (- 06/02/2025)***

4/22/25- Staff member A re-trained on resident privacy. Resident's unit was cleaned of moldy food in refrigerator while resident was out
6/11/2025- Executive Director to re-train staff on resident privacy. Community associates re-trained on resident rights and resident privacy.
June 12, 2024- The Executive Director will complete audits weekly x4 weeks and monthly x2 months of resident concerns to ensure resident privacy is being maintained.
Results of audit will be reviewed at Quality Management Meetings.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented (- 08/13/2025)

51 - Criminal Background Check

4. 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 requested a criminal background check for staff B, hired , on however, the home did not utilize a Pennsylvania State Police Criminal Background Check (ePatch).

The home rehired staff C on , whose original hire date was and whose criminal background check was completed on The home did not request a new criminal history check for staff C.

Repeat Violation: 07/15/2024 et al.

Plan of Correction ***Accept (- 06/02/2025)***

Criminal Background Check utilizing a Pennsylvania State Police Criminal Background Check for staff member B completed on 4/21/25.
Criminal Background Check utilizing a Pennsylvania State Police Criminal Background Check for staff member C completed on 4/23/25.
4/23/25- Executive Director re-trained Director of Business Administration (DBA) that prior to start date all

51 - Criminal Background Check (continued)

associates need a background check performed from the PA State police site.
5/30/25- Director of Business Administration will complete an audit of current active associates to ensure a background check utilizing a Pennsylvania State Police Criminal Background Check.
To assist with ongoing compliance DBA or designee will complete monthly audit x 3 months to ensure criminal background utilizing a Pennsylvania State Police Criminal Background Check are completed prior to start date and in associate file.
The Executive Director will review results of audits to determine if any further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

63a - First Aid/CPR Training

5. 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

On 04/12/2025 from 11:00 PM till 07:00 AM next morning, 44 residents were present in the home. During this time, no staff persons were present in the home who was trained in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

4/28/25- CPR class held for community clinical associates.
4/23/2025: Executive Director re-trained Director of Health & Wellness that at least 1 staff person for every 50 residents who is trained in first aid and certified in CPR shall be present in the home at all times.
5/1/25- HWD or designee will review daily schedules x 30 days and then weekly schedules for 2 months to ensure that at least 1 staff person for every 50 residents who is trained in first aid and certified in CPR is present in the home at all times.
The Executive Director will review results of audits to determine if any further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

65g - Annual Training Content

6. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff person D did not receive training in Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year 2024.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

4/25/25: Staff person D re-trained by Executive Director, who was trained as a train the trainer by a fire safety

65g - Annual Training Content (continued)

expert in Fire Safety.
5/13/25- Director of Business Administration re-trained by Executive Director that associates are required to have in Fire Safety completed by a fire safety expert or by a person trained by a fire safety expert annually.
5/30/25- Director of Business Administration will complete an audit by 5/30/25 of current associate files to ensure that initial fire safety training was completed and documented.
June 1, 2025- To assist with ongoing compliance DBA will complete weekly audits x 4 weeks and monthly for 2 months thereafter for newly hired associates to ensure their initial fire safety training was completed and documented.
ED will review results of audits to determine if any further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

96a - First Aid Kit

7. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the home's SDCU does not include tweezers.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

4/21/25- Tweezers placed in first aid kit in Memory support unit.
5/13/25- Clinical management re-trained by the Executive Director that tweezers must be included in community first aide kits.
5/28/25- Resident Engagement Coordinator or designee, will complete an audit of community first aid kits to ensure they contain all regulatory items.
June 1, 2025- To ensure on going compliance Memory Support Coordinator or designee, will complete audits weekly x4 weeks and then monthly x2 months thereafter to ensure that community first aid kits include all regulatory items. Executive Director will review results of audits to determine if any further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

102k - No Common Towel

8. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

On 04/21/2025 at 09:48 AM, there was a used towel in the shared bathroom in resident room #133. Two residents utilize this bathroom. The towel was not labeled with a resident name and there were no paper towels, mechanical hand dryer or other sanitary means of hand drying in this bathroom.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

4/21/25- Dirty towel in shared unit 133 was removed. Two new towels were put in place and labeled with the

102k - No Common Towel (continued)

names of each resident who uses the bathroom.
June 11, 2025: Community staff re-trained by Executive director that for shared bathrooms Individual cloth hand towels that are labeled with each resident's name who uses the bathroom must be located at or near each sink.
June 12, 2025- Memory Support Director will complete audits 5x weekly of shared bathrooms to ensure individual cloth hand towels that are labeled with each resident's name who uses the bathroom is located at or near each sink.
June 13, 2025- To assist with ongoing compliance the Memory Support Director or designee will complete weekly audits x 8 weeks to ensure that individual cloth hand towels that are labeled with each resident's name who uses the bathroom is located at or near each sink.
Executive Director will review results of audits to determine if any further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

103e - Left Overs

9. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 04/22/2025 around 09:50 AM, there was a plate with three pieces of pie, unlabeled and undated, in the main kitchen refrigerator. There was a tray of ice cream cups, unlabeled and undated, in the main kitchen walk-in freezer.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

4/22/25- Plate with 3 pieces of pie located in the main kitchen refrigerator that were unlabeled and undated were immediately removed and disposed of. 4/22/25- The tray of ice cream cups located in the main kitchen walk in freezer that were unlabeled and undated were immediately removed and disposed of.
6/11/2025- Dining staff re-trained but Executive Director that all left over food must be labeled and dated.
5/28/25- Dining Director completed audit of community kitchen to ensure that all left over food is labeled and dated.
June 1, 2025- To assist with ongoing compliance, Dining Director or designee will complete daily audits for 30 days and then weekly audit x8 weeks to ensure all left over food is labeled and dated.
Executive Director will review the results of audits to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

103g - Storing Food

10. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 04/22/2025 around 09:50 AM, a tray of ice cream cups that was partially covered and partially uncovered was found in the main kitchen freezer.

103g - Storing Food *(continued)*

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

4/22/25- Tray of ice cream cups that were partially covered and partially uncovered in the main kitchen freezer were immediately removed and disposed of.
5/28/25: Dining Director completed an audit of community kitchen to ensure that food is stored in a closed or sealed container.
6/11/2025- Dining staff re-trained by Executive Director that food shall be stored in closed or sealed containers.
June 1, 2025- To assist with ongoing compliance, Dining Director or designee, will complete daily audits for 30 days and then weekly audits for 8 weeks to ensure that all food is stored in closed or sealed containers.
The Executive Director will review the results of audits to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

103i - Outdated Food

11. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

A bag of waffles and a bag of chocolate cookies were observed in the refrigerator in the main kitchen. The original container, which would show expiration dates, was not present. The bags were not labeled with a date.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

4/22/25- Bag of waffles and a bag of chocolate cookies that were located in the refrigerator in the main kitchen, which were not in their original container that shows expiration dates, were immediately removed and disposed of.
5/28/25- Director of Dining services completed audit of kitchen freezers to ensure that items are in their original container which contains expiration date.
6/11/25- Dining staff re-trained by Executive Director that frozen items must be in their original container which contains expiration date.
6/1/25- To assist with ongoing compliance, the Dining Director or designee, will complete daily audits x30 days and weekly audits x8 weeks to ensure that frozen items are labeled with date opened.
The Executive Director will review results of audit and determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

105f - Labeling/Return of Clothes

12. Requirements

2600.
105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

Description of Violation

The home does not have a system to safeguard resident laundry from loss. Residents complain about laundry not washed as scheduled, missing items, clothing being damp upon return, and clothing not being returned within 24 hours.

105f - Labeling/Return of Clothes *(continued)*

Plan of Correction ***Accept (- 06/02/2025)***

June 11, 2025- Clinical community associates re-trained by Executive Director that residents' clean laundry must be returned with 24 hours.
June 12, 2025- Director of Health & Wellness or designee, will complete audits 5x weekly for 30 days and then weekly audits x 8 weeks to ensure residents clean laundry is returned within 24 hours.
The Executive Director will review results of audits to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented (- 08/13/2025)

107d - Procedure Emergency Management Agency Submission

13. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures were submitted to the local emergency management agency on 04/21/2025. The previous submission was on 02/24/2024.

Plan of Correction ***Accept (- 06/02/2025)***

4/21/25- Emergency Preparedness Plan was reviewed and submitted to Montgomery County Emergency Services Agency by Executive Director.
April 2025- Emergency preparedness plan will be reviewed and audited by Executive Director to ensure that it is submitted to the local emergency management agency.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented (- 08/13/2025)

109b - Rabies Vaccination

14. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 04/21/2025, one cat was present at the home. The home does not have a current certificate of rabies vaccination for this cat.

Plan of Correction ***Accept (- 06/02/2025)***

4/21/25: Community pet cat was taken for updated vaccinations.
5/7/2025- Executive Director re-trained concierge and Director of business administration that all pets must have current vaccines.
5/7/2025- Director of Business Administration complete an audit of community pets to ensure community has current certificate of rabies vaccination.
June 1, 2025- Director of Business Administration or designee, completed monthly audits for 3 months of community pets to ensure community has current certificate of rabies vaccination
Executive Director will review results of audit to determine if further action is required.

109b - Rabies Vaccination *(continued)*

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented (- 08/13/2025)

141b1 - Annual Medical Evaluation

15. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's annual medical evaluation was completed on . The resident's previous medical evaluation was completed on

Repeat Violation: 07/15/2024 et al.

Plan of Correction ***Accept (- 06/02/2025)***

4/22/25- Executive director re-trained Director of Health & Wellness that a resident shall have a medical evaluation: At least annually.
5/1/25- Director of Health & Wellness completed an audit of current residents DME forms to ensure that each resident has a medical evaluation: At least annually. Proof of audit will be auditor initials in corner of DME form.
To continue with on going compliance the Director of Health & Wellness or designee, will complete an audit of current resident DMEs for monthly x 3 months to ensure that each resident has a medical evaluation: At least annually. Proof of audit will be auditor initials in corner of DME form.
Executive Director will review the results of audits to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented (- 08/13/2025)

162c - Menus Posted

16. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The menus posted in the home's SDCU was for the week of 01/12/2025 and 01/19/2025.

Plan of Correction ***Accept (- 06/02/2025)***

4/21/25- Two-week menus from January of 2025 in the Memory Support Unit were immediately removed and menu for current week and following week were placed.
4/21/25- Executive Director re-trained Memory Care Director and Assistant Dining Director that the week's current menu as well as the following week's menu must be posted in a conspicuous place in the Memory Support unit.
5/1/25- To assist with ongoing compliance the Memory Care Director or designee will complete weekly audits x 12 weeks to ensure that the week's current menu as well as the following week's menu is posted in a conspicuous place in the Memory Support unit.
The Executive Director will review the results of the audits to determine if further action is required.

162c - Menus Posted *(continued)*

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

181f - Record of Medication

17. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 04/15/2025, resident #2's record did not include a current list of medications. The list in the resident's record does not include current prescription medication Lisinopril 20 mg and includes four prescription creams that the resident does not use or have. The list does not include OTC medications such as Meta-Mucil, Imodium, Nexium 24 HR, Benadryl, and etc.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

Resident #2 physician contacted for current med list. The current med list reviewed with resident to ensure medications resident has match physician orders.
5/13/25: Resident #2 & Director of Health & Wellness were re-trained by Executive Director that residents who self-administer medications have to have a physician order that matches the meds in which they are self-administering.
6/6/25: Director of Health & Wellness completed an audit of residents who self-administer medications to ensure that the medications they are self-administering are the medications on their physician orders.
To assist with ongoing compliance Director of Health & Wellness or designee, will complete monthly audits x 3 months to ensure residents who self-administer medications have medications that match their physician orders. Executive Director will review the results of the audits to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

182b - Prescription Medication

18. 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

Staff person C, hired on [redacted] administered Quetiapine Tab 50mg to resident #1 on 04/07/2025 and 04/09/2025. This staff person completed the paper version of the medication administration qualification course on 05/17/2024. The paper version became obsolete on 01/01/2024.

182b - Prescription Medication (continued)

Staff person D, hired [redacted], administered medications to resident #3 to include the following; Buspirone 5 mg, Lorazepam 0.5 mg, Magnesium Oxide 40 MG, Senna 8.6 mg, and Sertraline 25 mg on 04/22/2025 in the morning, . Staff person D completed the paper version of the medication administration qualification course on 05/17/2024, The paper version became obsolete on 01/01/2024.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

4/25/25- Staff person C took & passed the department's approved Medication Administration training program.
5/1/25: Staff person D took & passed the department's approved Medication Administration training program.
5/7/25- Executive Director re-trained Director of Health & Wellness that Medication Technicians must complete the department approved medication administration course.
5/2/25- Executive Director completed audit of active associate medication technicians to ensure that they have taken the department approved medication administration program. All community Medication Technicians noted to be in compliance.
June 1, 2025- To assist with ongoing compliance Executive Director or designee will complete monthly audits x 3 months of Medication Technician certifications to ensure they have taken & passed the department approved Medication Administration course.
Results will be reviewed at Quality Management Meetings.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

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 04/22/2025, Milk of Magnesia and Lidocaine Pain patches prescribed for resident #3 were in the home's 2nd floor medication cart; however, these medications are not listed on the resident's current medication list.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

Milk of Magnesia and Lidocaine Pain patch re-ordered and added to Resident # 3 medication list.
5/30/25- Director of Health and Wellness to complete cart audits to ensure that medication in medication carts are listed on resident's medication list or disposed of per company policy.
6/11/25- Medication Technicians and Nurses re-trained by Direct or Health and Wellness that only current prescriptions, OTC, sample and CAM for individuals living in the home may be kept on medication cart.
6/12/25- Director of Health & Wellness or designee, will complete monthly audits x 3 months to ensure that only current prescriptions, OTC, sample and CAM for individuals living in the home may be kept on medication cart. Executive Director will review the results of the audit to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

185a - Implement Storage Procedures

20. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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 #5 is prescribed accuchek four times a day. The resident's glucometer was not calibrated to correct time. It displayed 11:13 AM at 12:03 PM on 04/22/2025. The resident's actual reading on the machine on 03/31/2025 at 07:03 AM was 141, which was documented as 172 on the log.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

5/23/25- Currently no insulin dependent diabetics reside within the community.
6/11/25- Medication Technicians and Nurses re-trained by Director of Health & Wellness that glucometers need to be calibrated to correct date and time as well as correctly transcribed from Glucometer to medication record.
June 12, 2024- To assist with ongoing compliance the Director of Health and Wellness will complete Monthly audits x3 months of resident glucometers to ensure they are calibrated to correct date and time as well as correctly transcribing information from Glucometer to medication record.
Executive Director will review the results of the audit to determine if further action is required

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

21. 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 Lorazepam 0.25 ml every four hours as needed. The declining inventory log for this medication reached the end on 04/16/2025 with 11 as remaining balance. The current remaining count is 9. There is no additional inventory log showing the current count.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

Resident #6 Lorazepam .25ml every four hours as needed matches on EMAR- coinciding with date of delivery. No medication diversion noted.
6/11/25- Medication Technicians and Nurses re-trained by Director of Health & Wellness that resident narcotics need to be signed out on both inventory log and EMAR.
June 12, 2024- Director of Health & Wellness Director or designee will complete 5x weekly audits for 30 days and then weekly audits for 2 months thereafter to ensure that Narcotic count matches with inventory log.
Executive Director will review the results of the audit to determine if further action is required

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #4 is prescribed Lorazepam 0.5 mg twice a day and every 24 hours as needed (PRN). The resident's morning dose has been retrieved from and signed out on the PRN narcotic control record since 04/15/2025. The narcotic control record for the straight order indicates that 0 pills were remaining after the 4/14/25 8AM administration of this medication.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

Resident #4 Lorazepam 0.5mg twice a day delivered from pharmacy.
June 11, 2025- Medication Technicians and Nurses re-trained by Director of Health & Wellness on Five rights of Medication Administration.
6/12/24- Director of Health & Wellness Director or designee will complete 5x weekly audits for 30 days and then weekly audits for 2 months thereafter to ensure that Narcotics being administered match what is being signed out on narcotic control record.
Executive Director will review the results of the audit to determine if further action is required

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

187a - Medication Record

23. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
9. Administration times.
13. Date and time of medication administration.

Description of Violation

Resident #3's medication administration record (MAR) list "AM" and "PM" as the administration time, not a specific time for the following medications:
Buspirone 5 mg, Lorazepam 0.5 mg, Magnesium Oxide 40 MG, Senna 8.6 mg, and Sertraline 25 mg. The resident's April MAR does not indicate the exact time of the administrations of these medications from 04/01/2025 through 04/20/2025.

Repeat Violation: 07/15/2024 et al.

Plan of Correction ***Directed ([redacted] - 06/02/2025)***

Requested removal for this deficiency. Electronic medication record does include time administered. Please see attached record for Resident #3 medication for April 1 to April 20, 2025 indicating the exact time of the administration.
Executive Director start date 4/14/25, survey date 4/21/25 & 4/22/25. Executive Director was still receiving training on EMAR system and was uncertain how to pull requested information. Executive Director will continue to train and learn systems of Symphony Square.

Proposed Overall Completion Date: 06/20/2025

187a - Medication Record (continued)

Directed Plan of Correction:

In addition to the above plan, within 15 days of the receipt of the acceptable plan of correction, the administrator shall educate all staff qualified to administer medications on the home's current eMAR system to include how to obtain reports on specific medication administration times.

Directed Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

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 #6 is prescribed Lorazepam 0.25 ml every four hours as needed. The resident's April MAR does not include the initials of the staff person who signed out and administered it on 04/09/2025 at 08:00 AM and 04/15/2025 at 07:00 PM.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

6/11/2025- Medication Technicians and Nurses retrained by Director of Health & Wellness that when administering narcotics, they must include the initials of the staff person who signed them out on the MAR.
June 12, 2024- Director of Health & Wellness Director or designee will complete 5x weekly audits for 30 days and then weekly audits for 2 months thereafter to ensure that when administering narcotics, the initials of the staff person who signed them out are included on the MAR.
The Executive Director will review the results of the audit to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

187d - Follow Prescriber's Orders

25. Requirements

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

Description of Violation

Resident #4 is prescribed Lorazepam 0.5 mg twice a day at 08:00 AM and 08:00 PM. The resident was not administered this medication on 04/18/2025 at 08:00 AM as evidenced by the declining inventory log of Lorazepam 0.5 mg. The balance of this medication was 6 on 04/22/2025 around 12:00 PM after 04/22 08:00 AM administration. There is no discrepancy or gap in the pill counts between 04/17 08:00 AM and 04/19 8:00 AM administration.
Repeat Violation: 07/15/2024 et al.

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

4/20/25- Resident # 4 physician notified of missed dose of Lorazepam 0.5mg on 4/18/25. No new orders at this time.
6/11/2025- Medication Technicians and Nurses retrained by Director of Health & Wellness that physicians orders must be followed and if a medication cannot be administered that physician must be notified.
June 12, 2024- Director of Health & Wellness Director or designee will complete 5x weekly audits for 30 days and then weekly audits for 2 months thereafter to ensure that narcotics are administered per physicians' orders.

187d - Follow Prescriber's Orders (continued)

Executive Director will review the results of the audit to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented (- 08/13/2025)

190b - Insulin Injections

26. 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 04/02/2025 at 04:00 PM, staff person E, hired on , checked resident #5's blood sugar level. However, staff E has not completed Department-approved diabetes patient education program within the past 12 months.

Plan of Correction ***Directed (- 06/02/2025)***

Community requests removal of this deficiency. Staff person E had department approved Diabetic training completed on 12/20/2024, however with new Executive Director in place certificate was not located until surveyors left community.
Please see attached proof of Diabetic training for Staff person E from 12/20/24.

Community hired new Business Office Manager (& New Executive Director BOM & ED implemented new structure for proper filing of employee files as well as Medication Technician Certification binder.

Proposed Overall Completion Date: 06/20/2025

Directed Plan of Correction:

In addition to the above plan, within 15 days of the receipt of the acceptable plan of correction, the administrator shall educate all staff involved in the management and monitoring of qualifications for staff to administer medication of the requirements of 190b.

Directed Completion Date: *06/20/2025*

Implemented (- 08/13/2025)

225c - Additional Assessment

27. 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.

Description of Violation

Resident #7's annual medical evaluation was completed on reflecting changes to the resident's dietary needs. However, an assessment was not completed. The most recent assessment and support plan (RASP) is dated and does not reflect the resident's change in the need for a pureed food diet.

225c - Additional Assessment *(continued)*

Plan of Correction ***Accept (- 06/02/2025)***

4/19/25- Resident # 7s RASP was updated to reflect the need for pureed food diet.
4/20/25- Director of Health & Wellness re-trained by Executive Director that if a resident's medical evaluation reflects changes to the resident's dietary needs, then an assessment, RASP, needs to be updated to reflect the need for the dietary change.
5/23/25- Health and Wellness Director completed audit of current residents to ensure that resident's medical evaluation regarding dietary needs is reflected on the RASP.
6/1/25- Health & Wellness Director or designee, will complete monthly audits x 3 months of current residents to ensure that resident's medical evaluation regarding dietary needs is reflected on the RASP.
Executive Director will review the results of the audit to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented (- 08/13/2025)

227g -Support Plan Signatures

28. 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 #8's assessment and support plan dated was not signed by the assessor.

Plan of Correction ***Accept (- 06/02/2025)***

4/19/25- Resident #8's assessment support plan dated was signed by the assessor.
4/20/25- Director of Health & Wellness was re-trained by Executive Director that residents support plans need to be signed by assessor.
5/23/25- Director of Health & Wellness completed audit of current residents' support plans to ensure they are signed by assessor.
To continue with ongoing compliance Director of Health & Wellness or designee, will complete monthly audits x3 months of current resident's support plans to ensure they are signed by assessor.
The Executive Director will review the results of the audit to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented (- 08/13/2025)

233d - Electronic/Magnetic System

29. Requirements

2600.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

On 04/22/2025 around 09:30 AM, the gate to the outside from the home's SDCU courtyard was not locked with an electronic or magnetic locking system. According to staff interview, during the weekly testing of the facility generator, this gate opens and stays open for about half an hour.

Plan of Correction ***Accept (- 06/02/2025)***

5/15/25- Community fire panel company came out and rewired fire panel to ensure that the gate outside from the

233d - Electronic/Magnetic System (continued)

hone's SDCU courtyard will remain locked with magnetic locking system during weekly testing of the facility generator.

6/1/25- To assist with ongoing compliance Maintenance Director or designee will complete weekly audits x4 weeks and monthly audits x 2 months on SDCU gate to ensure it remains locked during facility testing of generator.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

234a - Admission Support Plan

30. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #1 was admitted to the Secured Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

4/20/25- Director of Health & Wellness was re-trained by Executive Director that residents being admitted to Secured Dementia Care Unit shall have a support plan developed, implemented, and documented in the resident's record with 72 hours of admission.
5/14/25- Director of Health & Wellness completed an audit of current Secured Dementia Care Unit residents to ensure they have a support plan developed.
6/1/25- To assist with ongoing compliance Director of Health & Wellness will complete monthly audits x3 months of newly admitted residents to the Secured Dementia Care Unit to ensure they have a support plan developed, implemented, and documented in the resident's record within 72 hours of admission.
The Executive Director will review the results of the audit to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)

251b - Record Entries Legible

31. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

On the declining inventory log for resident #6's Lorazepam 0.25 ml, the time on the last two entries (04/15 and 04/16/2025) is illegible.

The dates (resident evaluated and form completed) on resident #7's annual medical evaluation for 2025 were written over.

251b - Record Entries Legible *(continued)*

Plan of Correction ***Accept ([redacted] - 06/02/2025)***

4/22/25- Health & Wellness Director re-trained by Executive Director that dates on annual medical evaluations cannot be written over.

5/29/25- A new DME was requested to be completed by physician for resident #7 to be completed within the next 30 days.

6/11/25- Medication Technicians & Nurses will be re-trained by Health & Wellness director that entries on the declining inventory log for narcotics must have legible times written in.

June 16, 2025- Director of Health & Wellness Director or designee will complete 5x weekly audits for 30 days and then weekly audits for 2 months thereafter to ensure that the declining inventory log for narcotics have legible times written in.

The Executive Director will review the results of the audit to determine if further action is required.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented ([redacted] - 08/13/2025)