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

June 9, 2025

[redacted]
HIDDEN MEADOWS OPCO LLC
[redacted]
WHITE OAK HEALTHCARE REIT
[redacted]

RE: HIDDEN MEADOWS ON THE RIDGE
THE LAURELS
340 FARMERS LANE
SELLERSVILLE, PA, 18960
LICENSE/COC#: 14524

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/01/2025 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**: *HIDDEN MEADOWS ON THE RIDGE THE LAURELS* **License #**: *14524* **License Expiration**: *07/20/2025*

**Address**: *340 FARMERS LANE, SELLERSVILLE, PA 18960*

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

## Administrator

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

## Legal Entity

**Name**: *HIDDEN MEADOWS OPCO LLC*

**Address**: [redacted]

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

## Certificate(s) of Occupancy

**Type**: *I-2* **Date**: *03/05/2014* **Issued By**: *Rockhill Township*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *82* **Waking Staff**: *62*

## Inspection Information

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

**Reason**: *Monitoring* **Exit Conference Date**: *05/01/2025*

## Inspection Dates and Department Representative

*05/01/2025 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *50* **Residents Served**: *41*

### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *Whole Home* **Capacity**: *50* **Residents Served**: *41*

### Hospice

**Current Residents**: *4*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0*

**Are 60 Years of Age or Older**: *41*

**Diagnosed with Mental Illness**: *0*

**Diagnosed with Intellectual Disability**: *0*

**Have Mobility Need**: *41*

**Have Physical Disability**: *0*

## Inspections / Reviews

### 05/01/2025 Partial

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/31/2025*

### 06/09/2025 - POC Submission

**Submitted By**: [redacted] **Date Submitted**: *06/09/2025*

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

## Inspections / Reviews *(continued)*

**06/09/2025 Bypass Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *06/09/2025*

**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 [redacted], at 9:29 AM, a resident diet book was unlocked, unattended, and accessible in green laundry basket in the dining area and postings of resident diets were found unlocked in each wing's pantry kitchen.*

*At 9:34 AM in the Dogwood pantry kitchen there were two completed resident shower/skin assessment sheets, were found unlocked, unattended, and accessible in the upper cabinets.*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*Immediately during inspection, the resident diet book and assessments were removed.*

*On Wednesday, May 28, 2025, staff trainings were held, discussing the topic of privacy and confidentiality. Please see attachments on this training.*

*Memory Care Director or Designee starting the week of May 19th, 2025 will be conducting daily audits to make sure no resident information such as diet sheets, assessments, or any other information is available to be seen by non-direct care staff. All binders or information will be located in a secured area at all times.*

*Executive Director will review audits on a weekly basis for the next two months or until substantial compliance has been achieved. In addition, Executive Director along with all department heads will be reviewing this violation and plan of correction during quarterly QA meetings. A summary from each QA meeting will be drafted and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented ([redacted] - 06/09/2025)***

## 65i - Training Record

**2. Requirements**

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

**Description of Violation**

*The home's record of direct care staff training that occurred on [redacted] does not include the source or length of training.*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*The training that occurred on 4/5/2025 was conducted by our Health and Wellness Director but he did not use the required training form that would have listed the mandatory information for the training record.*

## 65i Training Record (continued)

*Executive Director reviewed this training with the Health and Wellness Director and provided [redacted] with a blank copy of the training record to be used moving forward for all Hidden Meadows trainings.*

*Executive Director will review each training conducted by all Directors or trainers to make such the current training document is being used for each training. The Executive Director or Designee will keep these completed trainings together.*

*Executive Director will review audits on a weekly basis for the next two months or until substantial compliance has been achieved. During quarterly QA, Executive Director along with all department heads will be reviewing completed trainings reviewing that the correct information is listed on each training document. A summary from each QA meeting will be drafted and filed*

**Licensee's Proposed Overall Completion Date:** *05/27/2025*

***Implemented ([redacted] - 06/09/2025)***

## 81b - Resident Personal Equipment

**3. Requirements**

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

**Description of Violation**

*Resident[redacted] had a covered bed side mobility device attached to [redacted] bed that slides between the mattress and box spring. The device has a single strap that was around the box spring but was not tightened and had no tension. The device was able to be pulled away from the bed with little force creating approximately 1 foot entrapment zone between the side rails and the mattress.*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*Immediately during inspection, Director of Memory Care adjusted the straps to make sure they were tight enough so the enabler would not move.*

*Facilities Director along with Memory Care Director, and Health and Wellness Director will make sure all enablers used in the home are being properly installed following manufactures guidelines.*

*Weekly Audits starting the week of May 19th will be completed by Executive Director or designee to make sure all bed enablers are attached, and a cover is present between any space. Audits will continue for 2 months or until substantial compliance is achieved.*

*During quarterly QA meetings, total number of bed enablers will be discussed and reviewed to make sure compliance is being met. Next QA meeting is scheduled for 7 24 25. A summary from each QA meeting will be drafted and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS Directed the overall completion date only as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented [redacted] 06/09/2025)***

## 82b Poisonous Material Storage

**4. Requirements**

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

**Description of Violation**

*Multiple cans of labeled and unlabeled paint, including Valspar high-hiding primer/sealer with manufacturer's label indicating "if ingested call a poison control center", were stored on a wire rack in the same location as the homes emergency water supply.*

**Plan of Correction** ***Accept ( - 06/03/2025)***

*Director of facilities facilitated staff to relocated emergency water to a separate location free from any hazardous materials. See pictures.*

*Executive Director educated Director of facilities not to store any poisonous materials separate from any food.*

*Director of facilities will do weekly audits starting the week of May 19th for the next 2 months or until substantial compliance has*
*been achieved. This includes looking at hazardous and poisonous material and make sure its properly safeguarded and not located near any food items.*

*Executive Director will review facilities weekly audits over next 2 months or until substantial compliance has been achieved around poisonous materials.*

*During quarterly QA, Executive Director along with all department heads will discuss facilities weekly audits and make recommendations if problems have occurred. A summary from each QA meeting will be drafted and filed*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented ( 06/09/2025)***

## 82c Locking Poisonous Materials

**5. Requirements**

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

**Description of Violation**

*Envirex fresh concentrate 118 sanitizer and Virucide cleaner, with a manufacture's label indicating "Hazardous to humans and domestic animals, contact poison control if ingested", was unlocked, unattended, and accessible to residents under the sink in the Cedar kitchen. Not all the residents of the home have been assessed as capable of recognizing and using poisons safely.*

*Crest 3D White toothpaste, with a manufacture's label indicating "Contact poison control if ingested", was unlocked, unattended, and accessible to residents in room Not all the residents of the home, including residents who reside in room have been assessed as capable of recognizing and using poisons safely.*

## *82c Locking Poisonous Materials (continued)*

*Repeat violation: 04/04/2024 et al.*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*Immediately during inspection, Envirex fresh concentrate 118 sanitizer and Virucide cleaner were collected by Memory Care Director and Executive Director and placed in a locked location. All staff personnel on the floor at the time were reminded to never leave any poisonous material unlocked and unattended. Crest 3D White toothpaste was properly secured in the residents locked hygiene box.*

*Memory Care Director or designee will complete an audit by 5 30 25 of the community to check for any poisonous materials left unlocked, unattended or accessible to ensure safe keeping on*

*Memory Care Director along with Executive Director will educate nursing and housekeeping staff on regulation 82c locking poisonous materials by 5/29/25.*

*Executive Director or designee will conduct weekly safety checks over next 2 months or until substantial compliance has*
*been achieved to ensure no hazardous or poisonous materials are left unlocked, unattended, or accessible to residents of the home.*

*During quarterly QA, Executive Director along with all department heads will discuss audits related to regulation 82c and make recommendations if problems have occurred. A summary from each QA meeting will be drafted and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS Directed the overall completion date only as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented [redacted] - 06/09/2025)***

## 85a - Sanitary Conditions

**6. Requirements**

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

**Description of Violation**

*On [redacted] at 9:36 AM an orange liquid was spilled on 3 of the shelves in the Dogwood pantry kitchen refrigerator.*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*When spill was noticed, housekeeping was contacted to clean up the spilled orange juice.*

*Culinary staff along with direct staff at the home during inspection, were educated on the spot to make sure all refrigerators are clean and nothing is spilled.*

*Director of Culinary along with Executive Director discussed this violation at team meeting held on 5 7 25 and made all staff aware of the regulation that all food service areas, even areas in the neighborhoods need to be clean and sanitary at all times.*

## *85a - Sanitary Conditions (continued)*

*Executive Director and or Memory Care Director will be completing weekly rounds to make sure sanitary conditions are being meet. Audits will continue for 2 months or until substantial compliance achieved.*

*Sanitary condition audits will be discussed at quarterly QA meetings. Any areas that have issues will be discussed for proper plan of correction moving forward. The next QA meeting will be held on July 24, 2025. Minutes of this meeting will be documented and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented [redacted] 06/09/2025)***

## 103e - Left Overs

**7. 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**

*At approximately 9:30am, there was an unlabeled, undated and uncovered green salad with dressing in the Dogwood pantry refrigerator.*

**Plan of Correction** ***Accept [redacted] 06/03/2025)***

*Immediately during walk with inspector, Executive Director threw out the unlabeled salad and dressing.*

*Culinary staff along with direct staff at the home during inspection, were educated on the spot to make sure all food items are labeled correctly and stored appropriately.*

*Director of Culinary along with Executive Director discussed this violation at team meeting held on 5-7-25 and made all staff aware of the regulation that 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.*

*Executive Director and or Culinary Director will be completing daily audits starting 5/19/25 to make sure food items are labeled and*
*stored appropriately. Audits will continue for 2 months or until substantial compliance achieved.*

*Food Service food storage audits will be discussed at quarterly QA meetings. The next QA meeting will be held on July 24, 2025. Minutes of this meeting will be documented and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

## 103e - Left Overs *(continued)*

***Implemented [redacted] - 06/09/2025)***

## 103i - Outdated Food

**8. Requirements**

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

**Description of Violation**

*On [redacted] at 9:34 AM there were 2 pitchers of unlabeled, undated juice in the Dogwood pantry kitchen.*

*At 9:44 AM there were 3 unlabeled, undated pecan pies thawing on the counter in the main kitchen. In the walk-in refrigerator there were 2 pans of uncovered, unlabeled, and undated Jello, and 3 bottles of dressings that were unsealed, unlabeled and undated.*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*Immediately during walk with inspector, Executive Director threw out the unlabeled juice.*

*Culinary staff along with direct staff at the home during inspection, were educated on the spot to make sure all food items are labeled correctly and stored appropriately.*

*Director of Culinary along with Executive Director discussed this violation at team meeting held on 5-7-25 and made all staff aware of the regulation that outdated or spoiled food or dented cans may not be used. All food needs to have proper covering and label at all times, especially with leftovers, and juices or desserts.*

*Executive Director and or Culinary Director will be completing daily audits starting May19, 25 to make sure food items are labeled and*
*stored appropriately not just in the kitchen but throughout the homes other refrigerators that are in use. Audits will continue for 2 months or until substantial compliance achieved.*

*Food Service food storage audits will be discussed at quarterly QA meetings. The next QA meeting will be held on July 24, 2025. Minutes of this meeting will be documented and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented [redacted] 06/09/2025)***

## 132c - Fire Drill Records

**9. Requirements**

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

## 132c Fire Drill Records *(continued)*

**Description of Violation**

*The fire drill record for the supervised drill conducted on 3/17/2025 does not include the time of the drill, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.*

**Plan of Correction** ***Accept ( - 06/03/2025)***

*Immediately after inspection, Executive director reached out to Fire Safety expert to set up a Supervised Fire Drill for The Laurels.*

*Fire Safety expert came out on May 30, 2025, and provided a supervised Fire Drill along with written documentation.*

*Executive Director has educated Facilites Director on regulation requiring a Supervised Fire Drill is required annually by the fire safety expert and needs to include the time of the drill, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.*

*Supervised Fire Drills along with monthly Fire Drills will be recorded on monthly fire drill spreadsheets to maintain compliance along with documentation. Executive Director or designee will audit fire drills spreadsheet for 2 months or until substantial*
*compliance is achieved.*

*Proposed Overall Completion Date: 07/29/2025*
*MS Directed the overall completion date only as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented - 06/09/2025)***

## 141a 1-10 Medical Evaluation Information

**10. Requirements**

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

## 141a 1-10 Medical Evaluation Information *(continued)*

**Description of Violation**

*Resident [redacted] medical evaluation dated [redacted], did not include the ability to self-administer medications.*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*Health and Wellness Director was re-educated by Executive Director following the inspection on May 1, 2025, on*
*requirements of having a medical evaluation have all required areas completed.*

*All current residents' charts will be audited by Executive Director or Designee by 6-6-25 to make sure medical*
*evaluations are completed appropriately which includes medication assistance or independence.*

*Health and Wellness Director or designee will audit all residents' charts each month to make sure medical evaluations are completed accurately and within the approved timeframe. Audits will continue for 2 months*
*or until substantial compliance achieved.*

*During quarterly QA meetings, Executive Director will review residents who moved in during that quarter and make*
*sure, all required forms such as the medical evaluation have been completed. A summary from each QA meeting*
*will be drafted and filed.*

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

***Implemented ([redacted] - 06/09/2025)***

## 162c - Menus Posted

**11. 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 home's menu for the week of [redacted] was posted. However, the menu for the next week was not posted.*

**Plan of Correction** ***Accept ([redacted] - 06/03/2025)***

*During the inspection, the next weeks menu was added to the menu board showing both weeks are in place.*

*Executive Director educated Culinary Director directly about menu posting requirements. Current weeks menu place following weeks need to be posted in a common space viewable by residents.*

*Culinary Director will be responsible moving forward to make sure current week and next weeks are posted and changed accordingly.*

*Director of Memory care or designee will conduct weekly audits starting 5-19-25 to make sure the menus are*

## *162c - Menus Posted (continued)*

*posted, and the dates are accurate.*

*During quarterly QA meetings, Executive Director will review audits with team to make sure compliance is being met. Next QA meeting is scheduled for 7-24-25. A summary from each QA meeting will be drafted and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only, as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented [redacted] - 06/09/2025)***

## 183b - Meds and Syringes Locked

**12. 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 [redacted] at 9:25 AM, a tube of prescription anti-fungal cream belonging to resident [redacted], was unlocked, unattended, and accessible in the shared room of resident's [redacted] and [redacted].*

**Plan of Correction** ***Accept[redacted] - 06/09/2025)***

*Direct Care staff and nursing will keep all medication secured when not in use. Direct care staff and nursing during our checks on residents monitor for any medications or substances that could be harmful to the resident and secure them.*

*Director of Memory Care or Designee will do weekly safety checks starting week of 5/26/25 in each resident's room making sure all harmful materials are locked up appropriately. Any questionable items will be discarded and or kept in a safe area.*

*Staff was educated by Executive Director on 5-28-25 about locking items that can be harmful to residents.*

*During quarterly QA meetings, Executive Director will review audits with team to make sure compliance is being met. Next QA meeting is scheduled for 7-24-25. A summary from each QA meeting will be drafted and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only, as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/09/2025*

***Implemented [redacted] - 06/09/2025)***

## 183d - Prescription Current

**13. Requirements**

## 183d - Prescription Current *(continued)*

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 [redacted], [redacted] prescribed for resident [redacted], was found in the shared room of resident's [redacted] and [redacted]; however, the resident [redacted] no longer resides in the home as of [redacted].*

**Plan of Correction** ***Accept ([redacted] 06/09/2025)***

*Director of Health and Wellness discarded the anti-fungal cream immediately during inspection.*

*Upon passing of a resident, nursing staff with get all their medications together and destroy/dispose so no medication for non-residents is still at the home.*

*Director of Health and Wellness or designee will conduct weekly medication cart audits starting 5-30-25 to make sure only medication that belongings to current medication is stored.*

*Memory Care Director or designee will complete weekly resident room safety audits starting for two months or until substantial compliance is achieved.*

*Director of Health and Wellness started education on 5-27-25 to clinical team including nurses, med techs and care managers. Training will be completed by 6-6-25.*

*Medication audits will be discussed at quarterly QA meetings. Any areas that have issues will be discussed for proper plan of correction moving forward. The next QA meeting will be held on July 24, 2025. Minutes of this meeting will be documented and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only, as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented [redacted] - 06/09/2025)***

## 184a - Resident's Meds Labeled

**14. Requirements**

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

**Description of Violation**

*The pharmacy label for resident [redacted] does not include the resident's full last name and the prescribed dosage and instructions for administration. The label had been partially removed.*

## 184a - Resident's Meds Labeled *(continued)*

**Plan of Correction** ***Accept ( - 06/09/2025)***

*Health and Wellness Director immediately during inspection discarded the anti-fungus cream since the resident was no longer a current resident of the home.*

*Health and Wellness Director will provide education to nursing department by 6-6-25 to make sure all medication includes a*
*pharmacy label.*

*Health and Wellness Director or Nursing department will complete weekly medication cart audits starting 5-30-25 for two months or*
*until substantial compliance is achieved. see attached*

*Medication audits will be reviewed quarterly during QA to make sure all medication has a pharmacy label in place. Next QA meeting is scheduled for July 24, 2025. A summary from each QA meeting will be drafted and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only, as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/09/2025*

***Implemented - 06/09/2025)***

## 184b - Labeling OTC/CAM

**15. 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 a package of capsules with and belonging to resident was in the homes medication cart and was not labeled with the resident's name.*

*On a box of through belonging to resident was in the homes medication cart and was not labeled with the resident's name.*

**Plan of Correction** ***Accept 06/09/2025)***

*Bone Support pill capsules with Strontium and Boron belonging to resident was labeled with resident's name. Lifepak Anti-Aging through Nutrition supplement packets belonging to resident was labeled with the resident's name.*

*Health and Wellness Director will make sure all labels are clearly marked and if a label is damaged replace it with a label that has the missing information on it.*

*Health and Wellness Director will provide education by 6-6-25 to nursing department to make sure all medication includes a*
*pharmacy label.*

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

*Health and Wellness Director or Nursing department will complete weekly medication cart audits beginning 5-30-25 for two months or*
*until substantial compliance is achieved.*

*Medication audits will be reviewed quarterly during QA to make sure all medication has a pharmacy label in place. Next QA meeting is scheduled for July 24, 2025. A summary from each QA meeting will be drafted and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only, as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/09/2025*

***Implemented [redacted] - 06/09/2025)***

## 185a - Implement Storage Procedures

**16. 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**

*On [redacted], the home was unable to show the Agent of the Department resident [redacted] reading in [redacted] glucometer because staff did not know how to save the readings in the glucometer after completing the glucose check. Resident [redacted] has an order for sliding scale insulin coverage based on the residents glucose checks.*

**Plan of Correction** ***Accept ([redacted] - 06/03/2025)***

*Health and Wellness Director attended [redacted] own education on May 2, 2025 with the new ECP department on how to document the readings into Emar.*

*Health and Wellness Director completed re-educated of all staffed licensed practical nurses by 6-6-25 on how to save the readings in the glucometer after completing the glucose check. See attached*

*As an ongoing measure, Health and Wellness Director will also conduct weekly audits beginning 5-27-25 to ensure glucometer readings are being appropriately entered into the Emar record.*

*Audits will continue for two months or until substantial compliance to make sure glucometers readings are accurate, and*
*documentation is consistent.*

*Executive Director will review audits for glucometers at quarterly QA meetings. The next QA meeting is scheduled for July 24, 2025.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only, as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented ([redacted] - 06/09/2025)***

## 185a Implement Storage Procedures *(continued)*

**17. 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 [redacted] is prescribed [redacted] tablet every 4 hours as needed for pain and every 4 hours as needed for [redacted] every 4 hours as needed, and [redacted] take once daily as needed. On [redacted] these medications were not available in the home.*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*Immediately during inspection medication was ordered through pharmacy.*

*Health and Wellness Director will provide training to clinical team including med techs by 6-6-25 to make sure all resident's prescribed medication is available at the home.*

*Carts audits have started the week of May 30 by Nursing Department or Health and Wellness Director. Audits for continue for 2 months or until sufficient compliance is achieved.*

*During quarterly QA meetings, Executive Director will review residents who moved in during that quarter and make sure, all required forms such as the medical evaluation have been completed. A summary from each QA meeting will be drafted and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only, as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented [redacted] - 06/09/2025)***

## 187a Medication Record

**18. Requirements**

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident’s name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

## 187a - Medication Record *(continued)*

**Description of Violation**

*Resident [redacted] is prescribed [redacted] nit/ML pen inject subcutaneously 3 times a day per sliding scale: 101-150=4 units, 151-200=6 units, 201-250=8 units, 251-300=10 units, 301-350=12 units, 351-400=14 units. However, resident [redacted] April/2025 medication administration record does not indicate the number of units of insulin administered for any date/time.*

*Resident [redacted] is prescribed [redacted] nit/ML vial inject subcutaneously before meals and at bedtime per sliding scale: 200-300 = 2 units, 301-350 =3 units, 351-400 = 4 units, 401-600 5 units. However, resident [redacted] April/2025 medication administration record does not indicate the number of units of insulin administered for any date/time.*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*Health and Wellness Director attended [redacted] own education on May 2, 2025 with the new ECP department on how to document the*
*medication administration record to show the number of units of insulin administered for any date/time. See attached*

*Health and Wellness Director started on 5/27/25 by educating of all nursing and med techs on the process on how to document the medication administration record to show the number of units of insulin administered for any date/time. Completion of the training will be 6-6-25.*

*As an ongoing measure, Health and Wellness Director will also conduct weekly audits beginning 5-27-25 to ensure glucometer readings and units of insulin are being appropriately entered into the Emar record.*

*Audits will continue for two months or until substantial compliance to make sure glucometers readings are accurate, and*
*documentation is consistent.*

*Executive Director will review audits for glucometers at quarterly QA meetings. The next QA meeting is scheduled for July 24, 2025.*

*Proposed Overall Completion Date: 07/24/2025*
*MS- Directed the overall completion date only, as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented [redacted] - 06/09/2025)***

## 187b - Date/Time of Medication Admin.

**19. 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 [redacted] is prescribed [redacted] tablet once by mouth daily. Resident [redacted] April/2025*

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

*medication administration record does not include the initials of the staff person who administered this medication on [redacted] at 6 PM.*

*Repeat violation: [redacted] et al.*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*Health and Wellness Director was educated by Executive Director following the inspection on May 1, 2025, on requirements of having nurse or med tech initial each medication after administering.*

*Health and Wellness Director will educate of all nurses and med techs by 6 6 25 to make sure they are properly documenting that medication was administered.*

*Health and Wellness Director or designee will continue to randomly audit 10 residents EMARS each week starting 5 19 25 to make sure*
*initials are recorded accurately. Audits will continue for 2 months or until substantial compliance achieved.*

*During quarterly QA meetings, Executive Director will review EMARS monthly report for compliance. A summary from each QA meeting*
*will be drafted and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS Directed the overall completion date only, as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented [redacted] - 06/09/2025)***

## 231b - Medical Evaluation

**20. Requirements**

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

**Description of Violation**

*Resident [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident's medical evaluation was completed on [redacted]*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*Health and Wellness Director was re educated by Executive Director following the inspection on May 1, 2025, on*
*requirements of having a medical evaluation completed 60 days prior to admission.*

*All current residents' charts will be audited by Executive Director or Designee by 5 30 25 to make sure medical*
*evaluations are completed appropriately and accurately within 60 days of admission including.*

## *231b Medical Evaluation (continued)*

*Health and Wellness Director or designee will continue to audit all residents charts each month to make sure*
*medical evaluations are completed accurately and within the approved timeframe. Audits will continue for 2 months*
*or until substantial compliance achieved.*

*During quarterly QA meetings, Executive Director will review residents who moved in during that quarter and make*
*sure, all required forms such as the medical evaluation have been completed. A summary from each QA meeting*
*will be drafted and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS Directed the overall completion date only, as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

***Implemented [redacted] - 06/09/2025)***

## 233c - Key-Locking Devices

**21. Requirements**

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

**Description of Violation**

*The directions for operating the home's locking mechanism are not conspicuously posted near the door to the Secure Dementia Care Unit (SDCU)'s enclosed courtyard.*

*Repeat violation: [redacted] et al*

**Plan of Correction** ***Accept [redacted] - 06/03/2025)***

*Director of Memory Care posted the code to the door after the inspection was over. Photo attached.*

*Director of Memory care will add the door codes to monthly safety audit to ensure compliance.*

*Executive Director will perform random audits and review monthly safety audit to make sure all doors have required codes posted.*

*During quarterly QA meetings, all memory care door codes will be discussed and reviewed to make sure compliance is being met. Next QA meeting is scheduled for 7 24 25. A summary from each QA meeting will be drafted and filed.*

*Proposed Overall Completion Date: 07/24/2025*
*MS Directed the overall completion date only, as plan is acceptable.*

**Licensee's Proposed Overall Completion Date:** *06/03/2025*

233c Key Locking Devices *(continued)*

***Implemented ([redacted] - 06/09/2025)***