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

August 27, 2025

[redacted], AREA DIRECTOR OF OPERATIONS
WASHINGTON OPS LLC
[redacted]

RE: HAWTHORNE WOODS AL
791 LOCUST AVENUE
WASHINGTON, PA, 15301
LICENSE/COC#: 45409

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/05/2025, 05/06/2025 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: *HAWTHORNE WOODS AL* **License #**: *45409* **License Expiration**: *10/31/2025*

Address: *791 LOCUST AVENUE, WASHINGTON, PA 15301*

County: *WASHINGTON* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *WASHINGTON OPS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/16/1999* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *64* **Waking Staff**: *48*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/08/2025*

Inspection Dates and Department Representative

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

05/06/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *81* **Residents Served**: *46*

Special Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *46*

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

Have Mobility Need: *18* **Have Physical Disability**: *2*

Inspections / Reviews

05/05/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/23/2025*

05/27/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/21/2025*

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

Inspections / Reviews *(continued)*

05/30/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/28/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/08/2025*

08/27/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/08/2025*

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

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

Description of Violation

On 5/5/25, the license inspection summary, dated 1/12/24, et. al., was not posted in a conspicuous and public place in the residence.

On 5/5/25, the license inspection summary, dated 6/13/24, was located in a locked bulletin board cabinet near the dining room and was not accessible.

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

On 5/5/25, the Executive Director (ED) or designee posted the Licensing Inspection Summaries dated 1/12/24 and 6/13/24 on the bulletin board in a common area. The ED or designee also removed the locked cabinet and relocated all required information that had been stored inside to the publicly accessible bulletin board. The ED or designee will educate the leadership team on Regulation 3.d. by 5/30/25, and documentation of this education will be maintained. To ensure ongoing compliance, the ED or designee will audit the bulletin board weekly for four weeks to confirm that all required notices remain properly posted. (DIRECTED: The weekly audits shall begin on 6/5/25. [redacted] 5/30/25). The results of these audits will be reviewed during the next Quality Assurance meeting by June 8, 2025. (DIRECTED: The quality management review shall include a review of all items specified in 2800.26b. Documentation of the quality management review shall be kept. [redacted] 5/30/25).

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

5a1 DHS access

2. Requirements

2800.
5.a. The administrator, administrator designee or staff person designated under § 2800.56(c) (relating to administrator staffing) shall provide, upon request, immediate access to the residence, the residents and records to:
1. Agents of the Department.

Description of Violation

On 5/5/25 at 10:10am, agents of the Department requested access to 5 resident records; however, the records for the 5 residents were not provided to agents of the Department until 12:03pm.

REPEAT VIOLATION: 1/12/2024, et. al.

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

On 5/16/2025, the Executive Director (ED) or designee will request surveyor access to the electronic health record

5a1 DHS access (continued)

(EHR) system for resident records. Upon entry to the Community, the surveyor will be provided with a temporary login and will review records using the Community laptop. If the surveyor requests printed or PDF copies of any documents for inspection purposes, these will be provided the same day the request is made, either in printed form or via encrypted email. The ED will review this plan of correction during the next Quality Assurance meeting, to be held no later than June 8, 2025, to assess compliance with the applicable regulation. (DIRECTED: The quality management review shall include a review of all items specified in 2800.26b. Documentation of the quality management review shall be kept. [redacted] 5/30/25).

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

15a Resident abuse report

3. Requirements

2800.
15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On the morning of 4/26/25, resident #1 reported to direct care staff person A an allegation of physical abuse involving another direct care staff person towards resident #1; however, the incident was not reported to the local Area Agency on Aging until 4/28/25 at 6:54pm.

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

The Executive Director (ED) or designee provided training on mandated reporting to staff on 5/7/25. By 5/30/25, all staff will be trained on the prompt reporting of abuse or suspected abuse. Documentation of this training will be maintained in accordance with regulation 2800.65L. To ensure compliance, the ED or designee will audit five employee files weekly for four consecutive weeks to verify that mandated reporting training is completed upon hire and annually. (DIRECTED: The staff record reviews shall begin on 6/5/25. [redacted] 5/30/25). In addition, the ED or designee will review all internal incident reports daily to ensure timely reporting to the Area Agency on Aging (AAA) as required by regulation 2800.15a. (DIRECTED: The daily review of internal incident reports shall begin on 6/5/25. [redacted] 5/30/25). Incident reviews will be discussed at the next Quality Assurance meeting, to be held no later than June 8, 2025, and will include all elements outlined in regulation 2800.26b. (DIRECTED: Documentation of the quality management review shall be kept. [redacted] 5/30/25).

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

16c Incident reporting

4. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On the morning of 4/26/25, resident #1 reported to direct care staff person A an allegation of physical abuse involving another direct care staff person towards resident #1; however, the incident was not reported to the Department until 4/29/25 at approximately 11:00am.

REPEAT VIOLATION: 12/27/2024

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

The Executive Director (ED) or designee provided training on mandated reporting to staff on 5/7/25. By 5/30/25, all staff will be trained on the prompt reporting of abuse or suspected abuse. Documentation of this training will be maintained in accordance with regulation 2800.65L. To ensure compliance, the ED or designee will audit five employee files weekly for four consecutive weeks to verify that mandated reporting training is completed upon hire and annually. (DIRECTED: The staff record reviews shall begin on 6/5/25. [redacted] 5/30/25). In addition, the ED or designee will review all internal incident reports daily to ensure timely reporting to the Area Agency on Aging (AAA) as required by regulation 2800.15a. (DIRECTED: The daily review of internal incident reports shall begin on 6/5/25. The daily reviews shall include ensuring all reportable incidents specified in 2800.16a are reported to the Department within 24 hours in accordance with 2800.16c. [redacted] 5/30/25). Incident reviews will be discussed at the next Quality Assurance meeting, to be held no later than June 8, 2025, and will include all elements outlined in regulation 2800.26b. (DIRECTED: Documentation of the quality management review shall be kept. [redacted] 5/30/25).

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

18 Other laws, regs, ordins.

5. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. In addition, The Care Facility Carbon Monoxide Alarms Standards Act requires the date of battery installation to be present on the battery of all battery-operated carbon monoxide detectors. However, on the morning of 5/5/25, the date of battery installation was not present on the battery-operated carbon monoxide detector located in the 1st floor hallway near the kitchen/dining room.

18 Other laws, regs, ordins. *(continued)*

Plan of Correction ***Directed (- 05/30/2025)***

On the date of the survey, 5/5/25, the carbon monoxide detector battery was checked and replaced. The date of installation was marked directly on the battery to ensure clear identification. Beginning on 5/20/25, the Environmental Services Manager will conduct monthly audits of all carbon monoxide detectors for four consecutive months or until compliance is achieved. Thereafter, carbon monoxide detectors will be checked quarterly on an ongoing basis. Documentation of all audits will be maintained. The Executive Director (ED) or designee will review the progress of these audits during Quality Assurance meetings, with the next meeting scheduled no later than June 8, 2025, to ensure compliance with all aspects of regulation 2800.26.b. (DIRECTED: Documentation of the quality management review shall be kept. 5/30/25). Documentation of audits will be maintained.

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented (- 08/27/2025)

42b Abuse/Neglect

6. Requirements

2800.
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

On the morning of 4/25/25, direct care staff person B was assisting resident #1 with getting dressed to go to breakfast. Resident #1 told direct care staff person B did not want to get up yet and was swinging arms while sitting at bedside. Direct care staff person B continued to attempt to get resident #1 dressed and forcibly grabbed resident #1's lower right arm with hand, resulting in bruising to resident #1's lower right arm, measuring approximately 5cm long x 9cm wide.

Plan of Correction ***Directed (- 05/30/2025)***

On 5/7/25, the Executive Director (ED) or designee provided reeducation to all team members on the Escalation Reporting policy and procedure, emphasizing the importance of timely reporting of suspected abuse. Documentation of this training will be maintained. All team members will receive training on Residents' Rights, including the right to be free from abuse, during new hire orientation and annually thereafter. On Team Member B was terminated following substantiated allegations of abuse confirmed by both the Department of Human Services (DHS) and Adult Protective Services (APS). To ensure ongoing compliance, the ED or designee will audit five employee files weekly for four weeks to verify that mandated reporter training is completed upon hire and annually. (DIRECTED: The staff record reviews shall begin on 6/5/25. 5/30/25). Additionally, the ED or designee will check in with five residents each week to assess the delivery of care and confirm that residents feel safe in their environment. (DIRECTED: The resident interviews shall begin on 6/5/25 and be conducted in private. Documentation of the resident interviews shall be kept. 5/30/25). The next Quality Assurance meeting will be held no later than June 8, 2025, and will include a review of all items outlined in regulation 2800.26b. Documentation of this review will be maintained.

Proposed Overall Completion Date: 06/08/2025

42b Abuse/Neglect *(continued)*

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

56a Admin 36 hrs/week

7. Requirements

2800.
56.a. Except for temporary absences under subsection (b), the administrator shall be present in the residence an average of 36 hours or more per week, in each calendar month. At least 30 hours per week must be during normal business hours.

Description of Violation

According to numerous staff persons and staff person [redacted] the residence's administrator, staff person [redacted] was not present in the residence for an average of at least 36 hours per week during the month of April, 2025.

Plan of Correction ***Accept ([redacted] - 05/30/2025)***

The Area Director of Operations and the Executive Director Specialist, both qualified administrators for assisted living, will coordinate their schedules to ensure administrator coverage in compliance with regulation 2800.56a. Documentation of all administrator hours worked will be maintained to verify compliance with this requirement. A full-time Executive Director is scheduled to begin employment at the Community on 6/16/25. The next Quality Assurance meeting will be held no later than June 8, 2025, and will include a review of all items specified in regulation 2800.26b. Documentation of this review will be maintained.

Proposed Overall Completion Date: 06/08/2025

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

Implemented ([redacted] - 08/27/2025)

60a Staffing/support plan needs

8. Requirements

2800.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

The residence routinely does not have a staff person present in the residence who is qualified to administer medications during the 10:00pm-6:00am shift; however, there are numerous residents present in the residence who are unable to self-administer medications and are prescribed pro re nata (PRN) medications, including the following medications currently prescribed to resident #3:

- *Morphine Sulfate 100/5ml-Take 0.25ml by mouth/sublingually every 2 hours as needed for pain/shortness of breath*
- *Lorazepam 2mg/ml-Take 0.25ml sublingually every 3 hours as needed for agitation/restlessness*

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

The Executive Director (ED) or designee will educate the leadership team by 5/23/25 on meeting staffing

60a Staffing/support plan needs (continued)

requirements for the 10:00 p.m. to 6:30 a.m. shift, including the importance of ensuring a designated medication passer is scheduled to meet the anticipated needs of residents. The ED or designee will review the staffing schedule during Daily Stand Up meetings to confirm that coverage aligns with resident care and medication administration needs. (DIRECTED: Beginning on 6/5/25: The administrator/designee shall review the direct care staffing schedule daily to ensure a staff person qualified to administer medications is present in the residence 24 hours per day. [redacted] 5/30/25). The next Quality Assurance meeting will be held no later than June 8, 2025, and will include a review of all items outlined in regulation 2800.26b. Documentation of this review will be maintained.

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

63a First Aid/CPR 1:35

9. Requirements

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

On the following dates/times, there was only 1 staff person present in the residence who was trained in first aid and certified in obstructed airway techniques and CPR:

- *On 4/30/25 from approximately 10:00pm through 5/1/25 at approximately 6:00am*
- *On 5/2/25 from approximately 10:00pm through 5/3/25 at approximately 6:00am*
- *On 5/3/25 from approximately 10:00pm through 5/4/25 at approximately 6:00am*
- *On 5/4/25 from approximately 10:00pm through 5/5/25 at approximately 6:00am*

On 5/1/25 from approximately 10:00pm through 5/2/25 at approximately 6:00am, there were no staff persons present in the residence who were trained in first aid and certified in obstructed airway techniques and CPR.

On 4/30/25 and 5/1/25, 46 residents were present in the residence. On 5/2/25, 5/3/25, and 5/4/25, 47 residents were present in the residence.

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

The Executive Director (ED) or designee ensured that all overnight shift employees were certified in CPR and First Aid by 5/10/2025. Documentation of certification dates is maintained in employee files. Starting on 5/19/2025, the ED or designee will audit CPR and First Aid training documentation weekly [redacted] (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. The weekly audits shall continue indefinitely to ensure compliance with 2800.63a. [redacted] 5/30/25). to verify ongoing compliance and ensure that at least one staff member trained in CPR is scheduled for every 35 residents overnight.

The residence has developed a tracking system that includes CPR and First Aid certification and expiration dates for all current care staff. This system was implemented on 5/20/2025 and will be reviewed monthly by the ED or designee to ensure timely recertification. Documentation of tracking and monitoring will be maintained.
The next Quality Assurance meeting will be held no later than 6/8/2025. This meeting will include a review of all items specified in regulation 2800.26b, including CPR and First Aid training compliance, and documentation of the

63a First Aid/CPR 1:35 (continued)

review will be kept on file.

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

65i Training topics

10. Requirements

2800.
65.i. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the residence.

Description of Violation

Direct care staff person B, hired on [redacted], did not receive training on the following topics during the 2024 training year:

- *Medication self-administration training*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan*
- *Care for residents with mental illness. The residence currently serves 1 resident with a mental illness*

Direct care staff person D, hired on [redacted], did not receive training on the following topic during the 2024 training year:

- *Care for residents with mental illness. The residence currently serves 1 resident with a mental illness*

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

All required training will be completed by 5/30/2025, and documentation of staff education will be maintained in accordance with 2800.65L. The ED or designee began auditing 10% of employee files on 5/20/2025 and will continue weekly for four consecutive weeks or until consistent compliance is achieved.

DIRECTED: By 6/5/25: The administrator shall ensure direct care staff persons B and D have received training on all topics specified in 2800.65i. Documentation of the education shall be kept in accordance with 2800.65L. [redacted] 5/30/25

To ensure long-term compliance, the ED or designee will implement a tracking system by 6/1/2025 to monitor training completion and renewal dates. The system will be reviewed quarterly by the ED or designee to verify continued adherence. (DIRECTED: The quarterly training reviews shall begin on 6/5/25 to ensure all direct care staff persons receive training on all topics specified in 2800.65i during each training year. [redacted] 5/30/25). Training for new hires will be incorporated into the onboarding process, and annual retraining will be scheduled each calendar year.

65i Training topics (continued)

The ED or designee will be responsible for overseeing training, maintaining records, and conducting ongoing audits. The next Quality Assurance meeting will be held no later than 6/8/2025 and will include a review of training compliance and all other items specified in regulation 2800.26b. Documentation of this review will be maintained.

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

65j Annual training content

11. Requirements

2800.
65.j. 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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Direct care staff person B, hired on [redacted] did not receive training on the following topics during the 2024 training year:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations*

Direct care staff person D, hired on [redacted] did not receive training on the following topics during the 2024 training year:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert*

REPEAT VIOLATION: 1/12/2024, et. al.

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

All required training will be completed by 5/30/2025. Documentation of this training will be maintained in accordance with regulation 2800.65L.

65j Annual training content (continued)

DIRECTED: By 6/5/25: The administrator shall ensure direct care staff persons B and D have received training on all topics specified in 2800.65j. Documentation of the education shall be kept in accordance with 2800.65L. [redacted] 5/30/25

Audits of staff training files began on 5/20/2025. The ED or designee will review 10% of employee files weekly for four consecutive weeks to ensure compliance. Audit results will be documented and maintained.
To support long-term compliance, the residence implemented a training tracking system on 5/21/2025. This system includes training topics, completion dates, and renewal requirements. The ED or designee is responsible for overseeing training, maintaining the system, and monitoring completion and recertification status on a quarterly basis. (DIRECTED: The quarterly training reviews shall begin on 6/5/25 to ensure all direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers receive training on all topics specified in 2800.65j during each training year. [redacted] 5/30/25). The next Quality Assurance meeting will be held no later than 6/8/2025. This meeting will include a review of training compliance and all items specified in regulation 2800.26b. Documentation of the review and ongoing compliance efforts will be maintained.

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

91 Telephone Numbers

12. Requirements

2800.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 5/6/25, there were no emergency telephone numbers posted on or near the telephone in resident #2's living unit.

On 5/6/25, there were no emergency telephone numbers posted on or near the telephone in resident #3's living unit.

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

On 5/6/2025, the Executive Director (ED) or designee posted emergency telephone numbers next to the telephones in all resident apartments, including the living units of residents #2 and #3. A whole-house audit of all resident apartments was completed on 5/6/2025 by the ED to confirm that emergency contact numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management, and the assisted living complaint hotline were properly posted.
Beginning 5/20/2025, the ED or designee will audit 10% of apartment units weekly for four consecutive weeks to verify continued compliance. (DIRECTED: At the conclusion of the weekly audits, the ED/designee shall audit at least 10% of resident living units monthly to ensure compliance with 2800.91. [redacted] 5/30/25). The ED is responsible for

91 Telephone Numbers (continued)

conducting and documenting the audits, and any deficiencies will be corrected immediately.
The next Quality Assurance meeting will be held no later than 6/8/2025 and will include a review of compliance with emergency telephone number postings, along with all other items specified in regulation 2800.26b. Documentation of the audit results and Quality Assurance review will be maintained.

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

92 Windows/screens

13. Requirements

2800.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 5/6/25, no screens were present in the 2 windows in the living room area of resident #2's living unit. Both windows were open at the time of inspection.

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

Screens for the two windows in the living room area of resident #2's apartment were replaced on 5/7/2025. The Environmental Services Manager is responsible for this task and will ensure all screens are in place and in good condition.

A whole-house audit of all operable windows in the Community was completed on 5/8/2025 by the Environmental Services Manager to ensure that screens are present and in good repair. Any damaged or missing screens identified during the audit were repaired or replaced by 5/10/2025.
Beginning 5/20/2025, the Environmental Services Manager will audit 10% of apartment windows weekly for four weeks to verify that screens remain in place and are maintained in good condition. (DIRECTED: At the conclusion of the weekly audits, the ED/designee shall audit at least 10% of resident living units monthly to ensure compliance with 2800.92. [redacted] 5/30/25). All findings will be documented and retained for verification purposes.
The next Quality Assurance meeting will be held no later than 6/8/2025 and will include a review of compliance with regulation 2800.92 as well as all other items outlined in regulation 2800.26b. Documentation of the review will be maintained.

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

123b Emerg. procedures posted

14. Requirements

2800.
123.b. Copies of the emergency procedures as specified in § 2800.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the residence and a copy shall be kept.

Description of Violation

On the morning of 5/5/25, the emergency preparedness plan for the municipality in which the residence is located in were not posted in conspicuous and public place in the residence.

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

On 5/5/2025, a copy of the municipality's emergency preparedness procedures was posted in a conspicuous and public location at the front entrance of the residence. This action brought the Community into compliance with regulation 2800.123b. On 5/21/2025, the Executive Director (ED) re-educated the leadership team on the location of the posted emergency procedures and on the requirements of regulation 2800.123b. Documentation of this staff education will be maintained in accordance with 2800.65L.

To ensure ongoing compliance, the ED or designee will verify monthly that the emergency preparedness procedures remain posted and clearly visible. (DIRECTED: The monthly audits shall begin on 6/5/25 to ensure compliance with 2800.123b. [redacted] 5/30/25). Monitoring will be documented, and any issues identified will be corrected immediately. The next Quality Assurance meeting will occur no later than 6/8/2025. The meeting will include a review of the emergency procedures posting and all other items specified in regulation 2800.26b. Documentation of this review will be maintained.

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

132a Monthly fire drill

15. Requirements

2800.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The residence did not conduct an unannounced fire drill during the following months:

- *January, 2024*
- *March, 2024*
- *April, 2024*

An unannounced fire drill was attempted on 7/30/24 at 12:55pm; however, according to the fire drill records, the fire alarm was not operative on this day and residents were not evacuated. No other fire drill was conducted in July, 2024.

REPEAT VIOLATION: 1/12/2024, et. al.

132a Monthly fire drill *(continued)*

Plan of Correction ***Directed ([redacted] - 05/30/2025)***

The root cause of the missed fire drills was a failure to verify fire alarm functionality prior to the scheduled unannounced drill in July 2024 and a lack of oversight to ensure monthly compliance. To address this, the Executive Director (ED) or designee will ensure that unannounced fire drills are conducted monthly and documented in accordance with regulation 2800.132a. (DIRECTED: Beginning on 6/5/25: The administrator shall review all fire drill documentation monthly to ensure compliance with 2800.132a. [redacted] 5/30/25).

Monthly unannounced fire drills will begin in May 2025 and continue on an ongoing basis. Compliance will be verified for a minimum of four consecutive months, with the expectation that monthly fire drills will continue indefinitely. A designated staff member has been assigned to oversee the scheduling and execution of fire drills to ensure one is completed each month without exception.

The ED or designee will re-educate the leadership team and designated fire drill coordinator on proper fire drill procedures, including fire plan review and documentation requirements. This training will be completed by 5/22/2025. The ED will be responsible for conducting the training, and documentation of the training will be maintained in accordance with regulation 2800.65L.

To confirm compliance, the ED or designee will audit the fire plan and fire drill log by the end of each month to ensure drills were conducted and properly recorded.

The next Quality Assurance meeting will be held no later than 6/8/2025. The meeting will include a review of fire drill compliance and all other items outlined in regulation 2800.26b. Documentation of this review will be maintained.

Proposed Overall Completion Date: 06/08/2025

Directed Completion Date: *06/08/2025*

Implemented ([redacted] - 08/27/2025)

132c Fire drill records

16. Requirements

2800.
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 residence 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.

Description of Violation

The fire drill record for the fire drill held in October, 2024 at 5:45pm does not include the date the fire drill was conducted.

Plan of Correction ***Accept ([redacted] - 05/30/2025)***

The fire drill record for October 2024 was missing the required date, which resulted from inconsistent documentation practices and a lack of oversight. To address this issue and ensure full compliance with regulation 2800.132c, the Executive Director (ED) or designee will conduct unannounced fire drills monthly beginning in May 2025 and

132c Fire drill records (continued)

continuing indefinitely. Compliance will be verified for at least four consecutive months, with the expectation that drills and documentation will remain ongoing.
The ED or designee will audit the fire drill plan and fire drill documentation at the end of each month for four consecutive months, beginning May 2025, to verify that each drill includes the required components: date, time, evacuation time, exit route, number of residents/staff participating, any issues encountered, and confirmation that the fire alarm and smoke detectors were operational.
The ED will re-educate the leadership team and designated fire drill coordinator by 5/22/2025 on proper fire drill procedures, including accurate documentation requirements per regulation 2800.132c. The ED will conduct this training, and documentation of staff education will be maintained in accordance with regulation 2800.65L.
A designated staff member will be assigned responsibility for reviewing all fire drill documentation monthly to ensure completeness and accuracy. The Environmental Services Manager will serve in this role beginning 5/22/2025.
The next Quality Assurance meeting will take place no later than 6/8/2025 and will include a review of fire drill documentation and all other items outlined in regulation 2800.26b. Documentation of the review will be maintained.

Proposed Overall Completion Date: 06/08/2025

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

Implemented ([redacted] - 08/27/2025)

132i Testing fire alarm

17. Requirements

2800.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

According to the residence's fire drill records, the fire alarm was not activated during the fire drill held on 12/31/24 at 11:00pm.

Plan of Correction ***Accept ([redacted] - 05/30/2025)***

According to fire drill records, the fire alarm was not activated during the drill conducted on 12/31/2024 at 11:00 p.m. The root cause of this violation was a lack of clear accountability for ensuring the alarm was activated during each drill, as required by regulation 2800.132i.
To correct this, the Executive Director (ED) or designee will conduct monthly unannounced fire drills beginning in May 2025 and continuing indefinitely. Compliance will be verified for at least four consecutive months. The designated fire drill leader will ensure the fire alarm or smoke detector is activated during each drill.
The ED will re-educate the leadership team and designated fire drill coordinator on proper fire drill procedures, including the requirement to set off the alarm system during each drill. This training will be completed by 5/22/2025.
The ED will conduct the education, and documentation will be maintained in accordance with regulation 2800.65L.
The Environmental Services Manager will serve as the designated staff person responsible for reviewing all fire drill

132i Testing fire alarm (continued)

documentation monthly, beginning 5/22/2025, to verify compliance with 2800.132i and to ensure that the fire alarm or smoke detector was activated during each drill. The ED or designee will also audit fire drill documentation by the end of each month for four consecutive months to ensure compliance and proper recording.
The next Quality Assurance meeting will take place no later than 6/8/2025 and will include a review of fire drill practices and documentation, along with all other items outlined in regulation 2800.26b. Documentation of the review will be maintained.

Proposed Overall Completion Date: 06/08/2025

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

Implemented ([redacted] - 08/27/2025)

133.2 Exit signs - direction

18. Requirements

2800.
133.2. Access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

On 5/5/25, the arrow indicating the directions for travel to the emergency exit door next to the family dining room was pointing in the opposite direction of the emergency exit.

Plan of Correction ***Accept ([redacted] - 05/30/2025)***

On 5/5/2025, the Executive Director (ED) designee corrected the exit sign located near the family dining room that was improperly oriented, with the arrow pointing in the opposite direction of the emergency exit.
On 5/6/2025, a full audit of all exit signs in the Community was conducted by the Environmental Services Manager (ESM) to ensure proper directional accuracy. All signs were verified and found to be compliant, or were corrected as needed on the same day.
The ED or designee will conduct training with the Environmental Services Manager by 5/27/2025 regarding the proper placement and directional alignment of all exit signage, in accordance with regulation 2800.133.2. Documentation of this training will be maintained in accordance with regulation 2800.65L.
To ensure ongoing compliance, the Environmental Services Manager will conduct weekly audits of all exit signs beginning 5/27/2025 and continuing for four consecutive weeks. Findings will be documented, and corrective action will be taken immediately for any discrepancies identified.
The next Quality Assurance meeting will be held no later than 6/8/2025 and will include a review of exit sign compliance along with all other items specified in regulation 2800.26b. Documentation of this review will be maintained.

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

Implemented ([redacted] - 08/27/2025)

133.2 Exit signs - direction *(continued)*

183d Current medications

19. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 5/6/25, resident #2's Jardiance-10mg tablets were present in resident #2's medication roll pack; however, this medication was discontinued by the prescriber on 4/22/25.

Plan of Correction ***Accept ([redacted] - 05/30/2025)***

On 5/6/2025, the Health and Wellness Director (HWD) confirmed that resident #2's prescription for Jardiance 10mg tablets had been discontinued by the prescriber on 4/22/2025. The HWD removed the discontinued medication from the medication cart and destroyed it per the Disposal of Medication policy.
To prevent recurrence, the HWD provided training on 5/22/2025 to all licensed staff and Medication Passers on the Medication Policies and Procedures. The training emphasized that discontinued medications must be removed from the medication cart immediately, secured per policy, and the pharmacy must be notified for reprocessing. Documentation of this training is maintained in accordance with regulation 2800.65L.
The HWD or designee will begin weekly audits on 5/27/2025, reviewing 10% of resident medication carts for four consecutive weeks to verify that discontinued medications are properly removed and destroyed per policy. Any discrepancies will be addressed and documented immediately. After the four-week period, monthly audits will continue as part of the Community's long-term monitoring process.
The next Quality Assurance meeting will be held no later than 6/8/2025 and will include a review of medication discontinuation practices and all other items outlined in regulation 2800.26b. Documentation of this review will be maintained.

Proposed Overall Completion Date: 06/08/2025

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

Implemented ([redacted] - 08/27/2025)

184a Resident meds labeled

20. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

184a Resident meds labeled *(continued)*

Description of Violation

Resident #3 is currently prescribed, "Hyoscyamine 0.125mg tablet-Take 1 tablet by mouth every 4 hours as needed"; however, on 5/6/25, resident #3's pharmacy label indicated, "Hyoscyamine 0.125mg tablet-Take 1 tablet by mouth every 3 hours as needed".

Plan of Correction ***Accept ([redacted] - 05/30/2025)***

On 5/6/2025, the Health and Wellness Director (HWD) corrected the discrepancy on resident #3's medication container by applying a change-in-direction sticker to reference the Medication Administration Record (MAR), ensuring that the pharmacy label aligned with the prescribed directions for administration.

On 5/22/2025, the HWD conducted training with all Medication Passers on the community's Medication Policies and Procedures. The training included guidance on verifying that pharmacy labels match the MAR, recognizing discrepancies, and the proper use of change-in-direction stickers. Documentation of this training is maintained in accordance with regulation 2800.65L.
Beginning 5/27/2025, the HWD or designee will audit 10% of resident medications weekly for four consecutive weeks to verify that the pharmacy label matches the directions documented on the MAR. Findings will be documented, and any inconsistencies will be corrected immediately. Following the four-week audit period, monthly medication audits will continue to ensure ongoing compliance.
The next Quality Assurance meeting will be held no later than 6/8/2025 and will include a review of medication labeling compliance along with all other items specified in regulation 2800.26b. Documentation of this review will be maintained.

Proposed Overall Completion Date: 06/08/2025

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

Implemented ([redacted] - 08/27/2025)

185a Storage procedures

21. Requirements

2800.
185.a. The residence 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 #2 is currently prescribed, Nitroglycerin 0.4mg tablet-Place 1 tablet under the tongue every 5 minutes up to 3x/15 minutes as needed; however, on 5/6/25, this medication was not present in the residence for administration.

REPEAT VIOLATION: 1/12/2024, et. al.

Plan of Correction ***Accept ([redacted] - 05/30/2025)***

On 5/5/2025, the Health and Wellness Director (HWD) identified that resident #2's prescribed Nitroglycerin 0.4mg

185a Storage procedures (continued)

tablet was not present in the residence for administration. The HWD reordered the medication the same day. Upon delivery, the medication was placed on the medication cart and made available for use per the physician's orders.
On 5/22/2025, the HWD conducted training with all Medication Passers on the community's Medication Policies and Procedures. The education emphasized that all prescribed medications must be stored securely in the medication cart, available for administration as ordered, and routinely monitored for availability. Documentation of the staff education is maintained in accordance with regulation 2800.65L.
Beginning 5/27/2025, the HWD or designee will conduct weekly audits of 10% of residents' MARs and corresponding medication carts for four consecutive weeks to verify that all medications listed are present and accessible for administration. Any discrepancies will be corrected immediately and documented.
To support long-term compliance, monthly audits of medication availability and storage will continue after the four-week period. These audits will be conducted by the HWD or designee and reviewed regularly to ensure consistent adherence to safe storage procedures.
The next Quality Assurance meeting will be held no later than 6/8/2025 and will include a review of medication availability, storage procedures, and all other items specified in regulation 2800.26b. Documentation of the review will be maintained.

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

Implemented ([redacted] - 08/27/2025)

187a Medication record

22. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.

Description of Violation

On 5/6/25, resident #3's May 2025 medication administration record (MAR) included the following medication orders; however, this medication was discontinued by the prescriber on 5/1/25:

- *Ipratropium/Albuterol 0.5mg-3mg/ml-Use 1 vial via nebulizer every 6 hours*
- *Ipratropium/Albuterol 0.5mg-3mg/ml-Use 1 vial via nebulizer every 4 hours as needed*

REPEAT VIOLATION: 1/12/2024, et. al.

Plan of Correction ***Accept ([redacted] - 05/30/2025)***

On 5/6/2025, the Health and Wellness Director (HWD) confirmed that the Ipratropium/Albuterol order for resident #3 had been discontinued by the prescriber on 5/1/2025. The HWD immediately removed the discontinued medication from the Medication Administration Record (MAR) and faxed the discontinuation order to the pharmacy to ensure alignment.

187a Medication record (continued)

To prevent recurrence, the HWD conducted training for all Medication Passers on 5/22/2025. The training included instruction on medication policies and procedures, specifically emphasizing that discontinued medications must be promptly removed from the MAR. Staff were also instructed to notify the HWD immediately if a discontinued order remains on the MAR. Documentation of this education is maintained in accordance with regulation 2800.65L.
Beginning 5/27/2025, the HWD or designee will conduct weekly audits of 10% of resident MARs for four consecutive weeks to ensure all discontinued medications have been properly removed. Any discrepancies will be corrected immediately and documented.
Following the four-week audit period, monthly audits of MARs will continue to ensure long-term compliance with regulation 2800.187a.
The next Quality Assurance meeting will be held no later than 6/8/2025 and will include a review of medication record accuracy and all other items required under regulation 2800.26b. Documentation of this review will be maintained.

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

Implemented ([redacted] - 08/27/2025)

227d Support plan – med/dental

24. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

Resident #3 is currently receiving services from [redacted] Hospice; however, Resident #3's most recent support plan, dated [redacted], does not include the services or frequency of services resident #3 is currently receiving from [redacted] Hospice.

REPEAT VIOLATION: 1/12/2024, et. al.

Plan of Correction ***Accept ([redacted] - 05/30/2025)***

On 5/6/2025, the Health and Wellness Director (HWD) updated resident #3's support plan in the electronic health record (EHR) system to include services and frequency of care provided by [redacted] Hospice, ensuring compliance with regulation 2800.227d.
To prevent recurrence, the HWD provided training to all licensed nurses responsible for generating resident support plans. The training, completed on 5/22/2025, focused on verifying the inclusion of all medical, dental, behavioral health, and third-party provider services—including hospice and diagnoses—within each resident's support plan. Documentation of this education is maintained in accordance with 2800.65L.
Beginning 5/27/2025, the HWD or designee will conduct weekly audits of 10% of resident service plans for four consecutive weeks to verify that all required outside services and their associated frequencies are accurately reflected. Any discrepancies will be corrected and documented. After the four-week period, ongoing monthly audits will be implemented as part of the community's long-term monitoring system.

227d Support plan – med/dental (continued)

The next Quality Assurance meeting will occur no later than 6/8/2025 and will include a review of service plan documentation and all other items required under regulation 2800.26b. Documentation of this review will be maintained.

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

Implemented (- 08/27/2025)

254a Records – discharge/active

25. Requirements

2800.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 5/5/25 at 10:50am, a vacant office on the Garden Level was unlocked, unattended and accessible, and contained numerous current and past resident records, to include the following:

- *Resident #4's assessment and support plan, dated*
- *Resident #5's assessment and support plan, dated*
- *Resident #6's list of physician orders, dated*

Plan of Correction ***Accept (- 05/30/2025)***

On 5/5/2025 at 11:15 a.m., immediately following identification of the issue, the Health and Wellness Director secured the unlocked office on the Garden Level and relocated all current and past resident records to a designated locked storage area. A full review of record storage locations was conducted the same day to ensure no other records were left unsecured.
To prevent recurrence, the Executive Director (ED) or designee will provide training to the leadership team on verifying that all protected health information (PHI) is stored in a locked and restricted-access area. This training will be completed by 5/22/2025.
In addition, all staff members will receive education on regulation 2800.254a regarding the proper handling, storage, and security of resident records. This education will be conducted by the ED and completed by 5/30/2025. Documentation of the training will be maintained in accordance with 2800.65L.
Beginning 5/27/2025, the ED or designee will conduct weekly walkthroughs of all administrative and storage areas for four consecutive weeks to ensure that all resident records are secured and inaccessible to unauthorized persons. Following the four-week period, this monitoring will continue monthly as part of ongoing compliance verification.
The next Quality Assurance meeting will be held no later than 6/8/2025 and will include a review of record security procedures and all other items specified in regulation 2800.26b. Documentation of this review will be maintained.

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

Implemented (- 08/27/2025)