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

September 17, 2025

[redacted], LEGAL ENTITY
LCB CHADDS FORD LLC

RE: THE RESIDENCE AT CHADDS FORD
1778 WILMINGTON PIKE
GLEN MILLS, PA, 19342
LICENSE/COC#: 14536

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/07/2025, 05/08/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE RESIDENCE AT CHADDS FORD* **License #**: *14536* **License Expiration**: *12/06/2025*

Address: *1778 WILMINGTON PIKE, GLEN MILLS, PA 19342*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *LCB CHADDS FORD LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/08/2019* **Issued By**: *Chadds Ford Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *106* **Waking Staff**: *80*

Inspection Information

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

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

Inspection Dates and Department Representative

05/07/2025 - On-Site:
05/08/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *108* **Residents Served**: *75*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *24* **Residents Served**: *21*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *75*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *31* **Have Physical Disability**: *1*

Inspections / Reviews

05/07/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/06/2025*

06/16/2025 - POC Submission

Submitted By: **Date Submitted**: *07/07/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/18/2025*

Inspections / Reviews *(continued)*

06/16/2025 - POC Submission

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

09/17/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *07/07/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department’s personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident 1 is prescribed Oxycodone 5 mg tablet, take one by mouth twice daily. However, this medication was not administered to resident 1 on 4/22/2025 at 9:00 PM, the resident's 4/2025 MAR was marked as DNA or Did Not Administer. Staff report that the medication was not administered because the medication was not in the home, reporting that the resident's prescribing doctor did not reorder the medication timely. The home did not report this medication error to the Department.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/09/2025 the RCD assessed the resident for any adverse effects due to the missed dose of medication. The resident did not have any adverse effects.
The RCD/RSS/Designee will educate all nurses and med techs on the regulation and reportable incident requirements, by 06/16/2025. The education will include that any time they are documenting “Drug not available” or “Did not given” they must report it to the RCD/RSS/ED immediately so that a reportable incident can be completed if required.
To maintain ongoing compliance with reporting a missed med incident to the Department’s personal care home regional office and to follow the guidelines of this regulation, effective 05/19/2025 the staff person documenting “Drug not available” or “Drug not given” must report it to the RCD/RSS/ED/Designee who will then submit a reportable incident as required for any medication not administered as ordered. Compliance monitoring activities will be implemented under the supervision of the RCD/ED. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 09/15/2025)

82c - Locking Poisonous Materials

2. 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

On 5/8/2025 at 11:36 AM, a bottle of Trader Joe's lemon kitchen hand soap, with a manufacture's label indicating "External use only. Avoid contact with eyes. If skin irritation occurs. stop use and consult a physician. Keep out of reach of children. ", was unlocked, unattended, and accessible to residents in secure dementia care unit room 412. Not all the residents of the home, including residents of room 412, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/08/2025 the ED removed the hand soap from the apartment, at the time of the survey.

82c - Locking Poisonous Materials (continued)

The RCD/RD/RSS/ED will educate all care associates on this regulation and that any item indicating "Keep out of reach of children" or "Call poison control" must be locked in the Safe Haven toiletries lock box assigned to each individual resident. This education will be completed by 06/16/2025.
To maintain ongoing compliance with keeping poisonous materials locked and inaccessible to residents residing in memory care, effective 05/19/2025 the RD/RSS/Designee will perform Safe Haven apartment checks 2 times a week for 4 weeks to ensure compliance and understanding of the education that had been provided. Compliance monitoring activities will be implemented under the supervision of the RD/RSS/Designee. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 09/17/2025)

85d - Trash Receptacles

3. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/7/2025 at 9:29 AM there was a small brown uncovered trash can in the cafe area on the first floor that contained food wrappers and empty soda bottles.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/08/2025 the Maintenance Director replaced the open trash can with one that is covered and has a foot activated lid.
To maintain compliance on weekly environmental rounds, effective 5/8/2025 the Maintenance Director/Designee will ensure that trash cans in common area kitchens and bathrooms have lids. Any non-compliant trash can will be removed and replaced immediately. Findings will be documented and submitted to the QA Committee for further review and continuous improvement.

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

Implemented (- 09/17/2025)

103d - Storing Food Off Floor

5. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 5/8/2025 at 2:23 PM, one open box of pecan crunch tilapia filets was stored on the floor under a shelf and one box of McCain signature frites was stored on the floor in the walk-in freezer.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/08/2025 a delivery of frozen food was received during the Department's inspection, they immediately put the food in the freezer, to unpack and put away later in the shift. When found during the survey the ROD immediately

103d - Storing Food Off Floor (continued)

removed the food boxes from the floor.
On 05/14/2025 the ROD/ED educated the cooks on this regulation and that all food delivery boxes must be off the floor immediately upon delivery.
To maintain ongoing compliance, effective 05/19/2025 the ROD/Designee will perform weekly and random inspections for 4 weeks to ensure compliance and understanding of the education that had been provided.
Compliance monitoring activities will be implemented under the supervision of the ROD/Designee. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (█ - 09/17/2025)

107b - Emergency Procedures

6. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:
1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include contact information for each resident's designated person.

Plan of Correction ***Accept (█ - 06/16/2025)***

On 05/09/2025 the ED put a list of the responsible parties and their contact information for each resident in the Emergency Preparedness Binder.
Effective 6/2/2025 to ensure continued compliance the ED/BOD/Designee will update the emergency contact list in the Emergency Preparedness Binder for each resident's responsible party as the census changes.

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

Implemented (█ - 09/17/2025)

121a - Unobstructed Egress

7. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 5/7/2025 at 9:56 AM, a large red stop sign including the words "STOP" was adhered to the emergency exit door to

121a - Unobstructed Egress (continued)

stair well 2.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/07/2025 the RD removed the stop sign from the door.
The RD/RCD/RSS/ED will educate the care team on this regulation, with a completion date of 6/16/2025.
Effective 05/14/2025 to maintain ongoing compliance associates will ensure stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unobstructed during their routine rounds. Any deficiencies will be corrected immediately, reported to the RCD/ED/Designee and findings will be documented and submitted to the QA committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 09/17/2025)

141a 1-10 Medical Evaluation Information

8. 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.

Description of Violation

Section 7, ability to self-administer medications on resident 1's medical evaluation dated was edited post evaluation by the home on unspecified date. The edit did not include the information of the person who made the edits, when the person who completed the evaluation was contacted and proper documentation of that contact including date, time and person spoken to.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/12/2025 the RCD requested the resident see PCP and have a new DME completed with accurate information.
On 05/15/2025 the RCD received a new DME with all the required information.
All resident DMEs will be reviewed by 6/16/2025 to ensure they are compliant with this regulation. A new DME will be requested from the PCP for any DME found to be out of compliance.
The RCD/ED will educate all nurses by 6/16/2025 that when correcting an error on a DME they must document the date, time and the person they spoke to confirming the correction, The RCD/ED must be made aware of and review all corrections made to ensure compliance.
To maintain ongoing compliance, effective 05/12/2025 the RCD/ED will review new DMEs weekly, at the time they are received or when corrections are made to ensure they are complete, accurately reflect the residents' needs and

141a 1-10 Medical Evaluation Information (continued)

any corrections were completed properly. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 09/17/2025)

144c2 - Smoking Area Distance

9. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The home's smoking policy indicates the community is "Smoke Free" and there are "no smoking" signs posted at entrances. The policy does not indicate a designated smoking area. On 5/8/2024, a smoking tower was set up in front of a pillar by the parking lot leading to the main entrance of the building, and at a bench at the sidewalk near the entrance. There was also a smoking area set up in the back of the parking lot.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/08/2025 the Maintenance Director removed the smoking/cigarette butt tower from next to the bench, it was supposed to be located at the end of the walkway at the parking lot. The table at the corner of the property is there to allow associates to have a place to sit and enjoy the outdoors during their breaks. This is not a designated smoking area, and there are no smoking/cigarette butt towers at that location.
On 05/08/2025 the Maintenance Director placed the smoking/cigarette butt towers at the end of the walkways where they meet up with the parking lot. This is to encourage visitors to discard the butts appropriately and not throw them on the ground. The community believes these smoking/cigarette butt towers need to remain in place to help ensure that cigarette butts are discarded properly, as we cannot control if a visitor walks from the parking lot to the building with a cigarette, but we can help to ensure the proper clean disposal of the butts.
As of 05/09/2025 all department leaders will monitor for proper safe placement of the smoking/cigarette towers during routine walking rounds.
The ED/BOD will educate all associates on the no-smoking policy, with a completion date of 6/16/2025.
The ED/BOD/Maintenance Director will educate new residents and family members of the no-smoking policy at the time of move in by review of the resident handbood.
The ED/BOD will educate the existing residents on the no-smoking policy at the next resident council meeting on 6/12/2025.
Effective 06/2/2025 compliance monitoring activities will be implemented under the supervision of the all-department leaders. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 09/17/2025)

162c - Menus Posted

10. 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

On 5/8/2025, in the home's secure dementia care unit, the menu was only posted for lunch and dinner for 5/6, 5/7, and 5/8. There was no weekly menu or advance menu posted.

Repeat violation: 5/8/2024 et al.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/08/2025 the RD posted the menu in the memory care neighborhood to include meal selections for 1 week in advance.
To maintain ongoing compliance each Monday, beginning 5/12/2025 during rounds the RD/ROD/Designee will confirm that the menu is posted 1 week in advance in a conspicuous and public place in the memory care neighborhood. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/04/2025*

Implemented (- 09/17/2025)

171b5 - First Aid Kit

11. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the bus used to transport residents does not include antiseptic, because the anti-septic wipes in the kit had expired on 9/15/2024.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/08/2025 the RED removed the expired antiseptic wipes from the first aid kit and replaced them with new ones. The expiration date of the wipes was added to the inventory list on the outside of the kit.
To maintain ongoing compliance beginning 06/09/2025 the Van Driver/RED/Designee will assess the first aid kit monthly and replace the antiseptic if it is reaching its expiration date.
Compliance monitoring activities will be implemented under the supervision of the RED. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/04/2025*

Implemented (- 09/17/2025)

181c - Self-administration Assessment

12. Requirements

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

Description of Violation

Resident 1 self-administers medications to include Iprat-Albut inhalation solution nebulizer four times a day, Ipratropium 0.06% nasal solution- two sprays in each nostril twice a day, and Acetaminophen ER 650 mg capsule take 1 tablet by mouth every 6 hours as needed; however, resident 1 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/12/2025 the RCD requested the resident see PCP and have a new DME completed with accurate information.
On 05/15/2025 the RCD received a new DME with all the required information.
All resident DMEs will be reviewed by 6/16/2025 to ensure they are compliant with this regulation. A new DME will be requested from the PCP for any DME found to be out of compliance.
On 5/16/2025 the RCD/ED educated all nurses that when correcting an error on a DME they must document the date, time and the person they spoke to confirming the correction, The RCD/ED must be made aware of and review all corrections made to ensure compliance.
To maintain ongoing compliance, effective 05/12/2025 the RCD/ED will review new DMEs weekly, at the time they are received or when corrections are made to ensure they are complete, accurately reflect the residents' needs and any corrections were completed properly. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 09/17/2025)

181f - Record of Medication

13. Requirements

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

Description of Violation

On 5/8/2025, resident 4's record did not include a current list of medications. The list in the resident's record did not include Glucosamine 1500 mg/Chondroitin 1200 mg, however this medication was present in resident's unit.

On 5/8/2025, resident 5's record did not include a current list of medications. The list in the resident's record had the following discrepancies:
- Atorvastatin 10 mg tablet-one by mouth one time per day was on the medication list; however, the medication resident had in possession was Atorvastatin 20 mg.
- Sertraline HCL 25 mg tablet- one by mouth one time per day, was on the medication list; however, the medication resident had in possession was sertraline HCL 50 mg.

181f - Record of Medication (continued)

- Vitamin D 1000 units was on the medication list; however, the medication resident had in ██ possession was vitamin D 2000 units.
- Cranberry 250 mg capsule on the medication list; however, the medication resident had in ██ possession was one bottle of Vita Up urinary tract health 8000 mg and Ultra Cranberry 1000 mg.
- Yuvafem tablet 10 mcg, Tramadol hcl 50 mg, Ondansetron hcl 8 mg tablet, Mirtazapine 15 mg tablet, Dexamethasone 1 mg tablet and Clindamycin ph 1% gel were listed on the resident's medication list but these medications are no longer in the home.

Plan of Correction ***Accept (██ - 06/16/2025)***

On 05/12/2025 the RCD requested the resident see ██ PCP and have a new DME completed to include an accurate medication list.
On 05/14/2025 the RCD educated the resident on the need to report any medication order changes to the care team, and to provide an updated list of all medications whenever changes are made.
On 05/14/2025 the RCD received a new DME, complete with a medication list. The list was printed and given to the resident for self-administration.
The medication list for each resident who self-administers will be reviewed by 6/16/2025 to ensure they are complete and accurate. If any discrepancies are found, the resident will be requested to see their PCP, for completion of a new DME to include an accurate list of all medications.
To maintain ongoing compliance effective 05/12/2025 the RCD/RSS/Designee will review the resident's medication list monthly, or when there are reported changes to ensure the medication list and the medication supply match. The RCD/RSS/Designee will ensure the resident's record includes a current list of prescription, CAM and OTC medications for each resident who is self-administering their medication.
Compliance monitoring activities will be implemented under the supervision of the RCD. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (██ - 09/17/2025)

183b - Meds and Syringes Locked

14. 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 5/8/2025 at 10:31 AM, two loose tablets of Acetaminophen were unlocked, unattended, and accessible in resident 1's room on a tray in front of ██ chair, and a tub of zinc oxide ointment was unlocked, unattended and accessible in ██ bathroom. Resident 1 has not been evaluated to self-administer medications.

183b - Meds and Syringes Locked *(continued)*

Plan of Correction ***Accept (- 06/16/2025)***

On 05/08/2025the RCD removed the medications from the resident's apartment and properly disposed of them.
On 05/12/2025 the RCD requested the resident see PCP, be evaluated for self-administration and have a new DME completed.
On 05/14/2025 the RCD received a new DME, indicating the resident is no longer able to self-administer these medications.
The RCD/ED will educate the clinical team by 6/16/2025 to be alert for and report any medications found in a resident's apartment to the supervisor on duty. This will ensure prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked. The supervisor will assess the situation and remove the medications if the resident's DME indicates they are not able to self-administer them and report the findings to the RCD/RSS/ED.
Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 09/17/2025)

183d - Prescription Current

15. Requirements

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

Description of Violation

On 5/8/2025, Lidocaine 4% patches prescribed for resident 6, was in the home's medication cart; however, the medication was discontinued on 1/22/2025.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/08/2025 the RCD removed the medication from the cart and properly disposed of it.
The RCD/ED will educate the nurses by 6/16/2025 on the procedure to properly discontinue a medication.
Beginning on 05/19/2025 the RCD/RSS/Designee will review discontinued orders weekly for 4 weeks to ensure compliance and understanding of the education that had been provided.
Beginning on 5/19/2025, if on the weekly review discontinued medications are found in the cart the RCD/RSS will provide individual coaching to the nurse who received the discontinue order and was responsible for removing it from the cart and properly disposing of it.
Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 09/17/2025)

183e - Storing Medications

16. Requirements

2600.

183e - Storing Medications *(continued)*

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

Description of Violation

On 5/8/2025 the following blister packs of medications were observed in the home's medication carts:
- Resident 1's Lorazepam 5 mg 1 tablets- the foil/paper backing of the blister packaging was torn at pill 23 and taped over, the pill remained inside the packaging.
- Resident 6's tramadol 50 mg- the foil/paper backing of the blister packaging was torn at pill 5 and taped over, the pill remained inside the packaging.
- Resident 7's alprazolam .25 mg- the foil/paper backing of the blister packaging was torn at pill 23, the pill remained inside the packaging.

On 5/8/2025 the following was discovered in the home's medications carts:

Resident 8's Lantus solo star insulin pen was opened and undated. Manufacturer's instructions indicate the unused medication must be discarded 28 days after opening.

Resident 9's - twelve Lorazepam 2 mg/ml prefilled syringes were present in the medication refrigerator however, they expired on 8/18/2024.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/08/2025 the RCD removed the medications that were in the torn blisters and properly discarded them.
On 05/09/2025 the RCD requested different packaging from the pharmacy which has greater puncture resistance.
On 05/12/2025 the Pharmacy began packaging medications in stronger, more puncture resistant packages.
On 05/08/2025 the RCD verified the date the Lantus syringe was opened and properly labeled it with the date it must be discarded (28 days after opening).
The RCD/ED will educate the nurses and med techs by 6/16/2025, that all medications found to be in a punctured open blister must be discarded immediately and that all insulin pens must be dated with the date opened and discarded per manufacturer's recommendations (usually 28 days after opening).
To maintain ongoing compliance with ensuring prescription medications, OTC medications and CAM are properly contained, effective 05/12/2025 the RCD/RSS/Designee will perform a medication cart review weekly and at random for 4 weeks to ensure compliance and understanding of the education that had been provided. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 09/17/2025)

184a - Resident's Meds Labeled

17. Requirements

2600.

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

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

Resident 4, who self-administers [redacted] medication, had a blue prescription bottle containing white pills present in their room. There was no label on the bottle and resident 4 could not identify what medication it was.

Plan of Correction ***Accept ([redacted] - 06/16/2025)***

On 05/08/2025 the ED removed the bottle and its contents from the resident's apartment and properly disposed of it. On 05/08/2025 the ED informed the resident and family of the removal of the items and educated them on the regulation. Informing them that all medications must be in their original containers, with proper labels identifying what they are.
To maintain ongoing compliance effective 05/19/2025 the RCD/RSS/Designee will review the medications of those residents who self-medicate, monthly when reviewing their medication list. or when there are reported changes to ensure the medications are in their original containers and properly labeled.
Compliance monitoring activities will be implemented under the supervision of the RCD. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

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

Implemented ([redacted] - 09/17/2025)

185a - Implement Storage Procedures

18. 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 resident 1's narcotic sign out sheet for Oxycodone hcl 5 mg, the medication was signed out twice on 4/28/2025 at 8 PM for both pills 50 and 49. This medication was not signed out at all on 4/29/2025. Resident 1's 4/2025 indicates [redacted] was administered this medication at 9 PM on 4/28/2025 and 4/29/2025 and was out of the facility at 9 AM on 4/29/2025. Resident has an order to receive this medication twice daily at 9:00 AM and 9:00 PM. The sign out for pill 49 was incorrectly dated and not corrected.

On 5/8/2025, resident 7 had two blister packs of Alprazolam .25 mg containing a total of 52 pills. The home's narcotic log indicated the resident last received this medication on 2/2/2025 at 9 PM. On 2/2/2025 the pill count documentation was incorrectly completed. In the on-hand column, it lists 53 pills remaining, in the amount given column it lists 1 given, and in the amount remaining column it shows a handwritten 53 comprised of a blue "5" and a black "3" written over a second number in blue. The home's narcotic accountability record indicates this medication was counted 8 times from 5/4/2024 to 5/8/2024 and that 53 pills were present. The home's narcotic policy states:

185a - Implement Storage Procedures (continued)

"All controlled medication should be counted and signed off by incoming and outgoing medication RN/Nurse/Tech. Counts should be done daily at the change of every shift with two signatures, the person leaving and the person coming on to the shift. If a discrepancy is discovered between the amount remaining on the narcotic inventory sheet and the number of tablets/capsules actually on hand, staff should: re-count again, determine when the last time the medication was given, and if appropriate documentation was completed". The home did not follow their policy for narcotic count discrepancies.

Repeated Violation: 12/9/24 et al.

Plan of Correction ***Accept (█ - 06/16/2025)***

On 05/09/2025 the RCD/RSS reviewed the Narcotic Sheet, verified the proper count, and verified the med tech who made the error. The med tech involved properly corrected the date for pill #49.
On 05/12/2025 the RCD/ED provided coaching to the staff person who made this documentation error, educating them on the last right on the list of 6 rights of Medication Administration which is the "Right Documentation" and that all documentation must be timely and accurate.
Beginning on 05/19/2025 the RCD/RSS/Designee will review the Narcotic logs weekly for 4 weeks, to ensure compliance and understanding of the education that had been provided. If repeated documentation errors are noted, for a staff person they will be removed from the duties of medication administration and further education will be provided, followed by verification of competency prior to being reinstated to medication administration.
Compliance monitoring activities will be implemented under the supervision of the RCD/Med Tech TTT. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (█ - 09/17/2025)

187a - Medication Record

19. 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.

187a - Medication Record *(continued)*

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.

Description of Violation

Resident 10 is prescribed glucometer readings and insulin injections 3 times a day based on a sliding scale: under 70 = 0 units, 70-100 = 5 units, 101-150= 14 units, 151-200 = 16 units, 201-250= 18 units, 251-300 = 20 units, 301-400= 23 units. However, resident's 5/2025 medication administration record does not indicate date and time of medication administration, glucometer reading and units of insulin administered on 5/5/2025 at 5 PM.

Repeat violation: 12/09/2024 et al

Plan of Correction ***Accept (- 06/16/2025)***

On 05/08/2025 the state surveyor confirmed with staff person A that the mediation had been administered as ordered, and the blood glucose reading had been obtained.
On 05/12/2025 the RCD/ED provided coaching to staff person A regarding the last right in the list of the rights to medication administration is "Right Documentation." Staff person A is required to review all MAR's at the completion of each of medication administration passed, to ensure all medications were administered and properly documented.
Beginning on 05/19/2025 the RCD/Med Tech TTT will review the MARS of staff person A weekly for 4 weeks to verify proper documentation. If further documentation omissions are noted, she will be removed from the duties of medication administration and further education will be provided, followed by verification of competency prior to being reinstated to medication administration.
Compliance monitoring activities will be implemented under the supervision of the RCD/Med Tech TTT. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 09/17/2025)

187b - Date/Time of Medication Admin.

20. 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 10 is prescribed glucometer readings and insulin injections 3 times a day based on a sliding scale: under 70 = 0 units, 70-100 = 5 units, 101-150= 14 units, 151-200 = 16 units, 201-250= 18 units, 251-300 = 20 units, 301-400= 23 units. Resident 10 's 5/2025 medication administration record does not include the initials of staff person A who administered insulin and took glucometer readings on 5/5/2025 at 5 PM. Staff person A verified via interview that a reading was taken and medication was administered on that date and time.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/08/2025 the state surveyor confirmed with staff person A that the mediation had been administered as ordered, and the blood glucose reading had been obtained.

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

On 05/12/2025 the RCD/ED provided coaching to staff person A regarding the last right in the list of the rights to medication administration is "Right Documentation." Staff person A is required to review all MAR's at the completion of each of ██ medication administration passed, to ensure all medications were administered and properly documented.
Beginning on 05/19/2025 the RCD/Med Tech TTT will review the MARS of staff person A weekly for 4 weeks to ensure compliance and understanding of the education that had been provided. If further documentation omissions are noted, ██ will be removed from the duties of medication administration and further education will be provided, followed by verification of competency prior to being reinstated to medication administration.
Compliance monitoring activities will be implemented under the supervision of the RCD/Med Tech TTT. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

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

Implemented (██ - 09/17/2025)

187d - Follow Prescriber's Orders

21. Requirements

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

Description of Violation

Resident 1 is prescribed Oxycodone 5 mg tablet, take one by mouth twice daily. However, this medication was not administered to resident 1 on 4/22/2025 at 9:00 PM because the medication was not available in the home.

Repeat violation: 12/09/2024 et al

Plan of Correction ***Accept (██ - 06/16/2025)***

On 05/09/2025 the RCD/ED reviewed resident #1's orders. This medication was a narcotic and was written for 30 days. The medication should have had a stop date of 4/21/2025, and marked completed/discontinued on the MAR. On 04/21/2025 the Wellness Nurse notified the physician that the order expired and inquired if ██ wanted to continue the order. A new prescription was received on 4/23/2025 and the medication was delivered that evening.
The RCD/ED will educate the nurses by 6/16/2025 on the procedure for verifying time limited medications.
To maintain ongoing compliance, effective 05/16/2025 the RCD/RSS/Designee will review new orders that are time limited, weekly for 4 weeks to ensure compliance and understanding of the education that had been provided.
Compliance monitoring activities will be implemented under the supervision of the RCD. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (██ - 09/17/2025)

188b - Medication Error Reporting

22. Requirements

2600.

188b - Medication Error Reporting *(continued)*

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident 1 is prescribed Oxycodone 5 mg tablet, take one by mouth twice daily. However, this medication was not administered to resident 1 on 4/22/2025 at 9:00 PM. The home could not provide documentation that this medication error was reported to the resident, and resident's designated person.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/09/2025 the RCD/ED reviewed resident #1's orders. This medication was a narcotic and was written for 30 days. The medication should have had a stop date of 4/21/2025, and marked completed/discontinued on the MAR. The resident is alert and oriented and it was confirmed with both the Med Tech who did not give the medication and the resident that the resident was aware the medication order had expired and needed to be reordered by physician.

On 04/21/2025 the Wellness Nurse notified the physician that the order expired and inquired if wanted to continue the order. A new prescription was received on 4/23/2025 and the medication was delivered that evening.

The RCD/ED will educate the nurses by 6/16/2025 on the procedure for verifying time limited medications.

To maintain ongoing compliance, effective 05/16/2025 the RCD/RSS/Designee will review new orders that are time limited, weekly for 4 weeks to ensure compliance and understanding of the education that had been provided. Compliance monitoring activities will be implemented under the supervision of the RCD. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Implemented (- 09/17/2025)

190c - Record of Training

23. Requirements

2600.

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person B does not include documentation of successful completion of the training.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/09/2025 the RCD/RSS removed staff person B from the duties of medication administration.

On 05/09/2025 the Med Tech TTT reviewed the Med Tech documents for all Med Techs to confirm the documents for initial training and testing were on file. All other Med Techs had the required documents.

On 05/09/2025 the RCD/ED met with staff B to review documentation needed per this regulation. Staff person B attempted to obtain the required documentation from previous employer. was not able to obtain it. Staff B has been removed from the Med Tech schedule and will not be reinstated until completes the full Med Tech course and the proper initial testing documents are secured.

To maintain ongoing compliance, effective 5/9/2025 the RCD and Med Tech TTT will review the Med Tech documentation prior to hiring a Med Tech who had completed the Med Tech course through another provider and ensure the initial training documentation is complete and compliant. If the documentation is not complete or

190c - Record of Training (continued)

compliant they will be required to repeat the Med Tech Training course with the community Med Tech TTT prior to functioning as a Med Tech.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 09/17/2025)

226a - Mobility Assessment

24. Requirements

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

On 5/8/2025, resident 11 has a bedside mobility device present by bed. Resident 11's most recent assessment and support plan was completed on and did not contain information related to the bedside mobility device.
When bedside mobility devices are being used, the Resident Support Plan must reflect:
The specific need for the device,
The intended Use,
Any risks associated with the device,
The resident's ability to use the device safely for the intended purpose,
Identification of the specific device to be used,
If a cover is required to meet FDA guidelines.

Plan of Correction ***Accept (- 06/16/2025)***

On 05/09/2025 the RCD completed a RASP which included the assessed need for a mobility handle on the side of the bed to allow for independent bed mobility
On 05/09/2025 the RCD/RSS reviewed all residents who use a mobility handle to ensure they were properly assessed, and the use is reflected on the RASP. No other residents were affected and the need for the mobility handle was reflected on their RASP.
To maintain ongoing compliance effective 06/04/2025 the RCD/RSS/ED will review RASPs upon completion to ensure that the need for a mobility handle is properly reflected. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 09/17/2025)

227g -Support Plan Signatures

25. Requirements

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

Description of Violation

Resident 2 participated in the development of support plan on However, the resident did not sign the support plan.

227g -Support Plan Signatures *(continued)*

Plan of Correction ***Accept (█ - 06/16/2025)***

On 05/09/2025 the RCD reviewed the RASP with the resident and secured the resident's signature as required.
To maintain ongoing compliance, effective 5/9/2025 the RCD/RSS/Designee will review completed RASPs to ensure that the resident has signed the RASP to indicate that they have participated in the development of the support plan.
Compliance monitoring activities will be implemented under the supervision of the RCD/ED. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (█ - 09/17/2025)

233c - Key-Locking Devices

26. 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

On 5/7/2025 the directions for operating the home's locking mechanism were not conspicuously posted near the door in the Secure Dementia Care Unit (SDCU) engagement room. An incorrect door code was posted.

Plan of Correction ***Accept (█ - 06/16/2025)***

On 05/07/2025 the RD posted the code at the time of the survey.
Beginning 05/12/2025 the RD/Designee will ensure that the code to the MC doors are posted and correct during routine walking rounds.
Effective 05/12/2025 compliance monitoring activities will be implemented under the supervision of the ED. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement.

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

Implemented (█ - 09/17/2025)

251b - Record Entries Legible

27. Requirements

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

Description of Violation

On resident 1's Lorazepam .5 mg narcotic count sheet line 6 is completely scribbled over and not legible.

On resident 7’s Alprazolam .25 mg narcotic log for 2/2/2025 the amount remaining column it shows a handwritten 53 comprised of a blue "5" and a black "3" written over a second number in blue. The number underneath the black "3" is not legible.

251b - Record Entries Legible (continued)

Repeat violation: 12/09/2024 et al

Plan of Correction ***Accept (- 06/16/2025)***

On 05/09/2025 the RDC confirmed who the staff person was that entered these illegible entries.
On 05/12/2025 the RCD/ED provided coaching to the staff person regarding the last right in the list of the rights to medication administration is "Right Documentation" and that all documentation must be legible and the proper way to correct an error.
Beginning on 05/19/2025 the RCD/RSS/Designee will review the Narcotic logs weekly for 4 weeks to ensure compliance and understanding of the education that had been provided. If repeated documentation errors are noted, for a staff person they will be removed from the duties of medication administration and further education will be provided, followed by verification of competency prior to being reinstated to medication administration.
Compliance monitoring activities will be implemented under the supervision of the RCD/Med Tech TTT. Any deficiencies will be corrected immediately, and findings will be documented and submitted to the QA Committee for further review and continuous improvement

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

Implemented (- 09/17/2025)