



Pennsylvania Department of Human Services

Emailing Date: August 28, 2025

[REDACTED]
[REDACTED]
Luther Ridge Facility Operations, LLC
160 Red Horse Road
Pottsville, Pennsylvania 17901

RE: Luther Ridge at Seiders Hill
License #: 224660

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on May 7, 2025, May 8, 2025 and July 1, 2025 and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

August 12, 2025

[REDACTED]
LUTHER RIDGE FACILITY OPERATIONS LLC
160 RED HORSE ROAD
POTTSVILLE, PA, 17901

RE: LUTHER RIDGE AT SEIDERS HILL
160 RED HORSE ROAD
POTTSVILLE, PA, 17901
LICENSE/COC#: 22466

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,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: LUTHER RIDGE AT SEIDERS HILL License #: 22466 License Expiration: 07/03/2025
Address: 160 RED HORSE ROAD, POTTSVILLE, PA 17901
County: SCHUYLKILL Region: NORTHEAST

Administrator

Name: [REDACTED]

Legal Entity

Name: LUTHER RIDGE FACILITY OPERATIONS LLC
Address: 160 RED HORSE ROAD, POTTSVILLE, PA, 17901
Phone: 5706217200 Email: LUTHERRIDGE.EXECUTIVEDIR@CONSULATEHC.COM

Certificate(s) of Occupancy

Type: C-2 LP Date: 06/23/1999 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 73 Waking Staff: 55

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: [REDACTED]
05/08/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity:	135	Residents Served:	62
Special Care Unit			
In Home:	No	Area:	Capacity:
Hospice			
Current Residents:	5		
Number of Residents Who:			
Receive Supplemental Security Income:	0	Are 60 Years of Age or Older:	62
Diagnosed with Mental Illness:	0	Diagnosed with Intellectual Disability:	0
Have Mobility Need:	11	Have Physical Disability:	0

Inspections / Reviews

05/07/2025 - Full
Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 05/31/2025

05/28/2025 - POC Submission
Submitted By: [REDACTED] Date Submitted: 05/23/2025
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 06/02/2025

Inspections / Reviews (*continued*)

07/25/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/29/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 07/28/2025

08/11/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/28/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

25b Contract signatures and renewal

1. Requirements

2800.

25b . The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident’s designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

Description of Violation

Resident #1’s contract dated [redacted]/25 was not signed by a second witness or legal representative as required by the home’s policy.

Plan of Correction

Do Not Accept [redacted] - 05/28/2025)

The contract was signed by the resident and the [redacted] on [redacted], under the oversight of the Director of Admissions. Going forward, all contracts will be signed at the time of the initial contract signing by the Administrator or their designee, the resident, and the payer. If the resident is unable to sign legibly, a second witness will be required. If the Administrator is unavailable, an assigned designee will assume their responsibilities.

Licensee’s Proposed Overall Completion Date: 06/03/2025

Update: 05/28/2025

Was an audit of all resident contracts completed? If so what date.
How will you prevent this violation from happening again?

Plan of Correction

Accept [redacted] - 06/10/2025)

The contract was signed by the resident and the [redacted] on 5/[redacted]/2025. On 5/28/2025, the Admissions Director was trained by the Administrator on the different methods for sending contracts and other paperwork to legal representatives. Additionally, an audit of all residents was completed by the Executive Director and Admissions Director. Moving forward, a monthly audit will be conducted by both the Admissions Director and the Administrator to ensure all contracts are signed by the Administrator or their designee, the resident, and the payer during the initial contract signing. If the Administrator is unavailable, an assigned designee will assume their responsibilities.

Licensee’s Proposed Overall Completion Date: 06/20/2025

Evidence of Completion

Implemented ([redacted] 07/28/2025)

See attached.

60a Staffing/support plan needs

2. 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 home’s current census of 66 residents includes 7 residents with mobility needs requiring the assistance of one staff person and 4 residents with mobility needs requiring the assistance of two staff persons. The residents requiring assistance of two staff persons are: Resident #2, Resident #3, Resident #4, and Resident #5. The residents requiring two person assist reside on the 1st and 3rd floors of the home. The direct care staff schedule for 4/1/25 to 4/30/25 indicates the home schedules only three staff persons during the 3rd shift hours of 11:00 p.m. to 7:00 a.m. The home is not scheduling an adequate number of staff on 3rd shift to safely evacuate all residents in the event of an emergency. Repeat violation 8/27/24, et al.

60a Staffing/support plan needs (continued)

Plan of Correction

Do Not Accept [REDACTED] **05/28/2025)**

Staffing was updated on May 10, 2025, by the Administrator and Scheduler to align with the needs of residents as outlined in their assessments and support plans. Moving forward, staffing levels will continue to be maintained in accordance with resident acuity levels.

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

Update: 05/28/2025

1. *What is the reason for the regulation?*
2. *What is the root cause of the violation?*
3. *How can we fix the immediate problem?*
4. *Once corrected, how can we make sure the problem does not happen again?*
5. *Who is responsible to fix the problem?*
6. *By what dates can each step in the plan be completed?*
7. *How will we monitor to be sure the plan is followed?*

Plan of Correction

Accept [REDACTED] **- 06/10/2025)**

The home was cited for insufficient staffing during the third shift hours of 11 p.m. to 7 a.m., which could impact the ability to safely evacuate all residents in the event of an emergency. On May 10, 2025, the Administrator and Scheduler updated staffing levels to align with residents' needs as outlined in their assessments and support plans. Going forward, staffing levels will be maintained according to resident acuity by the Scheduler, and the schedule will be monitored by both the Administrator and the Director of Nursing (DON).

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

Evidence of Completion

Implemented [REDACTED] **- 07/28/2025)**

The home was cited for insufficient staffing during the third shift hours of 11 p.m. to 7 a.m., which could impact the ability to safely evacuate all residents in the event of an emergency. On May 10, 2025, the Administrator and Scheduler updated staffing levels to align with residents' needs as outlined in their assessments and support plans. Going forward, staffing levels will be maintained according to resident acuity by the Scheduler, and the schedule will be monitored by both the Administrator and the Director of Nursing (DON). Also, with overnight call-outs,

60a Staffing/support plan needs (continued)

standard procedure is to contact off-duty staff to come in. If home is unable to find someone, staff will be mandated to stay. This was discussed at length at last mandatory staff meeting and will be addressed again during all future staff meetings.

64a Initial admin training

3. Requirements

2800.

64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:

- 1. An orientation program approved and administered by the Department.

Description of Violation

On 2/24/25 Staff person A began working in the home as the home's administrator. Staff person A did not complete an orientation program approved and administered by the Department.

Plan of Correction

Accept [redacted] - 05/28/2025)

Orientation has been scheduled for June 26, 2025, by the Administrator. Moving forward, the Administrator will ensure that all required training is completed appropriately and in a timely manner.

Licensee's Proposed Overall Completion Date: 06/27/2025

Evidence of Completion

Implemented [redacted] - 07/28/2025)

Orientation has been scheduled for June 26, 2025, by the Administrator. Moving forward, the Administrator will ensure that all required training is completed appropriately and in a timely manner.

65i Training topics

4. 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.

Description of Violation

Staff person B, who was hired [redacted]/13, and staff person C, who was hired [redacted]/90, did not receive training in medication self-administration or instruction on meeting the needs of the residents as described in the assessment tool, medical evaluation and support plan during 2024.

Plan of Correction

Accept [redacted] - 05/28/2025)

The training topic has been incorporated into the company-wide annual training program in Relias by the Regional Director of Nursing on 5/16/2025 and completed by all staff. Moving forward, all mandatory training will be completed in a timely manner in accordance with the requirements set forth by the Department of Human Services

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

Evidence of Completion

Implemented [redacted] - 07/28/2025)

The training topic has been incorporated into the company-wide annual training program in Relias by the Regional Director of Nursing on 5/16/2025 and completed by all staff. Moving forward, all mandatory training will be completed in a timely manner in accordance with the requirements set forth by the Department of Human Services

65j Annual training content

5. 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.
- 3. Resident rights.

Description of Violation

Staff person B, who was hired [redacted]/13, and Staff person C, who was hired [redacted]90, did not receive training in fire safety by a fire safety expert during 2024. Staff person C also did not receive training in resident rights during 2024.

Plan of Correction

Do Not Accept [redacted] - 05/28/2025)

The Fire Marshal from the Fire Department conducted fire safety training for all staff on May 21, 2025. Going forward, fire safety training will continue to be provided to all incoming staff during orientation by the Director of Maintenance.

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

Update: 05/28/2025

- 1. What is the reason for the regulation?
- 2. What is the root cause of the violation?
- 3. How can we fix the immediate problem?
- 4. Once corrected, how can we make sure the problem does not happen again?
- 5. Who is responsible to fix the problem?
- 6. By what dates can each step in the plan be completed?
- 7. How will we monitor to be sure the plan is followed?

Plan of Correction

Accept [redacted] - 06/10/2025)

The home was cited for not ensuring all staff had received fire safety training from a fire safety expert and training/education on residents' rights. On 5/21/2025, the Fire Marshal from the Fire Department provided fire safety training for all staff. All employee files have been updated to reflect this training. Additionally, on 5/16/2025, the Administrator provided education and materials on residents' rights to all staff, and employee files were updated accordingly. Going forward, incoming staff will receive fire safety training during orientation from our resident fire safety expert, the Director of Maintenance, and education on residents' rights from the Administrator or their designee.

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

Evidence of Completion

Implemented [redacted] - 07/28/2025)

The home was cited for not ensuring all staff had received fire safety training from a fire safety expert and training/education on residents' rights. On 5/21/2025, the Fire Marshal from the Fire Department provided fire safety training for all staff. All employee files have been updated to reflect this training. Additionally, on 5/16/2025, the Administrator provided education and materials on residents' rights to all staff, and employee files were updated accordingly. Going forward, incoming staff will receive fire safety training during orientation from our resident fire safety expert, the Director of Maintenance, and education on residents' rights from the Administrator or their designee.

95 Furniture & Equipment

6. Requirements

95 Furniture & Equipment (continued)

2800.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

At 9:10 a. m. the left side main elevator located in the lobby was inoperable. Staff and resident interviews indicated that the elevator had been inoperable for several weeks.

Repeat violation 5/7/24, et al.

Plan of Correction

Accept [redacted] - 05/28/2025)

The small elevator at the facility is currently awaiting parts, with repairs tentatively scheduled by the elevator company for May 30, 2025. Moving forward, the Director of Maintenance will ensure that all equipment and elevators are properly maintained, kept in good repair, and free of hazards.

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

Evidence of Completion

Implemented [redacted] 07/28/2025)

The small elevator at the facility is currently awaiting parts for repair from OTIS. In the meantime, the Administrator has contacted an alternate elevator company, KONE, to assess and complete the necessary repairs. A repair evaluation/elevator survey has been scheduled for Thursday, July 31, 2025. Moving forward, the Director of Maintenance will ensure that all equipment, including elevators, is kept in good repair and free of hazards.

132c Fire drill records

7. 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 home's fire drill logs indicate that on 4/28/25 at 3:10 p.m. a drill was conducted and that 65 residents were present in the home and all 65 residents were evacuated during the drill. Resident #2 was not evacuated during the drill held on 4/28/25 at 3:10 p.m. The home did not accurately document the number of residents evacuated during the fire drill held on 4/28/25.

Repeat violation 8/27/24, et al.

Plan of Correction

Accept [redacted] - 05/28/2025)

A fire drill was conducted on 5/7/2025 AND 5/23/2025, by maintenance director during which all residents were successfully evacuated. Training on fire drill and evacuation procedures for all staff was completed on 5/13/2025 by the Executive Director and the Director of Maintenance. Moving forward, refresher fire drill trainings will be conducted on a quarterly basis by the Director of Maintenance or designee and appropriately documented.

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

Evidence of Completion

Implemented [redacted] - 07/28/2025)

A fire drill was conducted on 5/7/2025 AND 5/23/2025, by maintenance director during which all residents were successfully evacuated. Training on fire drill and evacuation procedures for all staff was completed on 5/13/2025 by the Executive Director and the Director of Maintenance. Moving forward, refresher fire drill trainings will be

132c Fire drill records (continued)

conducted on a quarterly basis by the Director of Maintenance or designee and appropriately documented.

132g Fire drills – days/times

8. Requirements

2800.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home's fire drill logs indicate that fire drills were held on the following dates:

4/28/25, 3/24/25, 2/28/25, 1/31/25, 12/31/24, 11/27/24, 10/31/24, 9/30/24. The last 8 fire drills that the home conducted were all conducted on or close to the last day of the month.

Plan of Correction

Accept (█ - 05/28/2025)

A fire drill was conducted in the early evening hours on 5/7/2025 by the Director of Maintenance, and all residents were successfully evacuated. Going forward, fire drills will be conducted on varying days and at different times, both during the day and night, by the Director of Maintenance or their designee, ensuring evacuation is completed within the required time frame.

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

Evidence of Completion

Implemented (█ - 07/28/2025)

A fire drill was conducted in the early evening hours on 5/7/2025 by the Director of Maintenance, and all residents were successfully evacuated. Going forward, fire drills will be conducted on varying days and at different times, both during the day and night, by the Director of Maintenance or their designee, ensuring evacuation is completed within the required time frame.

132h Designated meeting place

9. Requirements

2800.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

Resident #2 was not evacuated during the fire drill conducted on 4/28/25 at 3:10 p.m. due to receiving hospice services.

Plan of Correction

Accept (█ - 05/28/2025)

A fire drill was conducted on 5/7/2025 AND 5/23/2025 by the Director of Maintenance, during which all residents were successfully evacuated. All future fire drills will be conducted on varying days and at different times by the Director of Maintenance or their designee. All residents, including those receiving hospice care, will be evacuated unless they are deemed to be actively dying. In such cases, a physician's certification is required, stating that the resident is actively dying and that participation in a fire drill may result in bodily injury or hastened death.

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

Evidence of Completion

Implemented (█ - 07/28/2025)

A fire drill was conducted on 5/7/2025 AND 5/23/2025 by the Director of Maintenance, during which all residents were successfully evacuated. All future fire drills will be conducted on varying days and at different times by the

132h Designated meeting place (continued)

Director of Maintenance or their designee. All residents, including those receiving hospice care, will be evacuated unless they are deemed to be actively dying. In such cases, a physician's certification is required, stating that the resident is actively dying and that participation in a fire drill may result in bodily injury or hastened death.

144c1 Smoking area guidelines**10. Requirements**

2800.

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

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the residence, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

At approximately 11:23 a.m., cigarette butts were observed on the grass surrounding the designated smoking area for staff.

Plan of Correction**Accept** [REDACTED] - 05/28/2025)

Cigarette butts found in the designated smoking area were removed on May 7, 2025, by the Maintenance Assistant. Moving forward, the designated smoking areas will be swept and maintained twice daily to ensure cleanliness, under the supervision of the Director of Maintenance.

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

Evidence of Completion**Implemented** [REDACTED] 07/28/2025)

Cigarette butts found in the designated smoking area were removed on May 7, 2025, by the Maintenance Assistant. Moving forward, the designated smoking areas will be swept and maintained twice daily to ensure cleanliness, under the supervision of the Director of Maintenance.

184a Resident meds labeled**11. 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.

Description of Violation

Resident #6 has an order for Acetaminophen 325mg, two tablets every 8 hours as needed. The pharmacy label for the medication incorrectly indicates the order is for two tablets 3 times daily.

Repeat violation 8/27/24, et al.

Plan of Correction**Accept** [REDACTED] - 05/28/2025)

On May 8, 2025, clinical staff under the supervision of the DON immediately corrected the resident's medication order and communicated with the pharmacy to ensure the correct medication was available and properly labeled. Staff education regarding a facility policy change related to pharmacy delivery and product labeling began on May 23, 2025. Daily audits will be conducted by designated clinical staff to compare each resident's medical record with the medications delivered. Additionally, a weekly cart audit will be performed to verify medication supply and ensure timely reordering, maintaining compliance with current regulations. Audit findings will be reviewed monthly

184a Resident meds labeled (continued)

during QAPI meetings.

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

Evidence of Completion

Implemented [REDACTED] - 07/28/2025)

On May 8, 2025, clinical staff under the supervision of the DON immediately corrected the resident's medication order and communicated with the pharmacy to ensure the correct medication was available and properly labeled. Staff education regarding a facility policy change related to pharmacy delivery and product labeling began on May 23, 2025. Daily audits will be conducted by designated clinical staff to compare each resident's medical record with the medications delivered. Additionally, a weekly cart audit will be performed to verify medication supply and ensure timely reordering, maintaining compliance with current regulations. Audit findings will be reviewed monthly during QAPI meetings.

185a Storage procedures**12. 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 #6 has an order for Imodium, 2mg every four hours as needed, and Senna Plus, one tablet daily as needed. The home did not have these medications available in the medication cart at 9:10 a.m. on 5/8/25.

Plan of Correction

Accept [REDACTED] 05/28/2025)

On May 8, 2025, clinical staff under the supervision of the DON immediately communicated with the pharmacy to ensure the correct medication was available to be delivered and properly labeled. Staff education regarding a facility policy change related to pharmacy delivery and product labeling began on May 23, 2025. Daily audits will be conducted by designated clinical staff to compare each resident's medical record with the medications delivered. Additionally, a weekly cart audit will be performed to verify medication supply and ensure timely reordering, maintaining compliance with current regulations. Audit findings will be reviewed monthly during QAPI meetings.

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

Evidence of Completion

Implemented [REDACTED] - 07/28/2025)

On May 8, 2025, clinical staff under the supervision of the DON immediately communicated with the pharmacy to ensure the correct medication was available to be delivered and properly labeled. Staff education regarding a facility policy change related to pharmacy delivery and product labeling began on May 23, 2025. Daily audits will be conducted by designated clinical staff to compare each resident's medical record with the medications delivered. Additionally, a weekly cart audit will be performed to verify medication supply and ensure timely reordering, maintaining compliance with current regulations. Audit findings will be reviewed monthly during QAPI meetings.

187a Medication record**13. Requirements**

2800.

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

6. Dose.

Description of Violation

Resident #7 has an order for Fluticasone, one spray in both nostrils one time daily. The Medication administration

187a Medication record (continued)

record incorrectly states the order is for two sprays in both nostrils one time daily.

Plan of Correction

Accept [REDACTED] /28/2025)

On May 8, 2025, clinical staff under the supervision of the DON immediately corrected the resident's medication order and communicated with the pharmacy to ensure the correct medication was available and properly labeled. Staff education regarding a facility policy change related to pharmacy delivery and product labeling began on May 23, 2025. Daily audits will be conducted by designated clinical staff to compare each resident's medical record with the medications delivered. Additionally, a weekly cart audit will be performed to verify medication supply and ensure timely reordering, maintaining compliance with current regulations. Audit findings will be reviewed monthly during QAPI meetings.

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

Evidence of Completion

Implemented [REDACTED] - 07/28/2025)

On May 8, 2025, clinical staff under the supervision of the DON immediately corrected the resident's medication order and communicated with the pharmacy to ensure the correct medication was available and properly labeled. Staff education regarding a facility policy change related to pharmacy delivery and product labeling began on May 23, 2025. Daily audits will be conducted by designated clinical staff to compare each resident's medical record with the medications delivered. Additionally, a weekly cart audit will be performed to verify medication supply and ensure timely reordering, maintaining compliance with current regulations. Audit findings will be reviewed monthly during QAPI meetings.

225b Assessment content**14. Requirements**

2800.

225.b. The assessment must, at a minimum include the following:

1. The resident's need for assistance with ADLs and IADLs.
2. The mobility needs of the resident.
4. The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.

Description of Violation

Resident #8 has an enabler bar attached to their bed to help assist with transferring out of bed. The Assessment and Support plan dated [REDACTED] /24 does not include the following information:

- The specific need for the device
- Any risks associated with the use
- The resident's ability to use the device safely for the purpose it was intended
- Identification of the specific device to be used and
- whether a cover is required to meet FDA guidelines

Resident #9 has a diagnosis of dementia with elopement seeking behaviors and requires the use of a roam alert device. The Assessment and Support plan dated [REDACTED] /25 for resident #9 does not include the need for the roam alert device.

Plan of Correction

Accept [REDACTED] - 05/28/2025)

The Assessment and Support Plans for Residents #8 and #9 were updated on May 9, 2025, by the Director of Nursing (DON) to reflect their mobility needs and the use of assistive devices. These updates detail each resident's ability to safely use the devices and their intended purpose.

Staff were educated on the proper use of enabler bars and wander guards, including associated risks, on May 9 and May 16, 2025. Going forward, all residents' Assessment and Support Plans will document the specific need for any assistive device, along with any potential risks related to its use.

225b Assessment content (continued)

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

Evidence of Completion

Implemented [redacted] - 07/28/2025)

The Assessment and Support Plans for Residents #8 and #9 were updated on May 9, 2025, by the Director of Nursing (DON) to reflect their mobility needs and the use of assistive devices. These updates detail each resident's ability to safely use the devices and their intended purpose.

Staff were educated on the proper use of enabler bars and wander guards, including associated risks, on May 9 and May 16, 2025. Going forward, all residents' Assessment and Support Plans will document the specific need for any assistive device, along with any potential risks related to its use.

254c Records – storing

15. Requirements

2800.

254.c. Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

Description of Violation

At 9:30 a.m., a box containing Medication Administration Records from 2022 with current residents' names, dates of birth and diagnoses was found in an unlocked storage closet on the first floor.

Plan of Correction

Accept [redacted] 05/28/2025)

Old records were appropriately disposed of by the Administrator and the Director of Nursing on May 7, 2025.

Current resident records will be stored in locked containers or within a secured, enclosed area designated solely for record storage. These records will remain accessible only to the Administrator, the Administrator's designee, or the nurse responsible for assessment and support plan development. Older resident records will be securely disposed of in an appropriate manner by the Administrator or their designee. Staff have been educated on proper procedures for storing current records and disposing of outdated records by the Executive Director and the Director of Nursing on May 13 2025.

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

Evidence of Completion

Implemented [redacted] - 07/28/2025)

Old records were appropriately disposed of by the Administrator and the Director of Nursing on May 7, 2025.

Current resident records will be stored in locked containers or within a secured, enclosed area designated solely for record storage. These records will remain accessible only to the Administrator, the Administrator's designee, or the nurse responsible for assessment and support plan development. Older resident records will be securely disposed of in an appropriate manner by the Administrator or their designee. Staff have been educated on proper procedures for storing current records and disposing of outdated records by the Executive Director and the Director of Nursing on May 13 2025.