



# Pennsylvania Department of Human Services

Sent via e-mail [REDACTED]  
July 17, 2025

[REDACTED]  
Heatherwood Retirement Investors, LLC  
[REDACTED]  
[REDACTED]  
[REDACTED]

RE: Heatherwood Retirement Community  
3180 Horseshoe Pike  
Honeybrook, Pennsylvania 19344  
License #: 10455

Dear [REDACTED] -

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on June 20, 2025 and July 17, 2025 of the above facility, we have determined that your submitted plan of correction for the May 12 and 13, 2025 inspection is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[REDACTED]

Enclosure  
Licensing Inspection Summary

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

**Facility Information**

Name: *HEATHERWOOD RETIREMENT COMMUNITY* License #: *10455* License Expiration: *06/03/2025*  
Address: *3180 HORSESHOE PIKE, HONEY BROOK, PA 19344*  
County: *CHESTER* Region: *SOUTHEAST*

**Administrator**

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

**Legal Entity**

Name: *HEATHERWOOD RETIREMENT INVESTORS LLC*  
Address: [REDACTED]  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *12/31/1984* Issued By: *L & I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *33* Waking Staff: *25*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal* Exit Conference Date: *05/13/2025*

**Inspection Dates and Department Representative**

05/12/2025 - On-Site: [REDACTED]  
05/13/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *50* Residents Served: *33*

**Secured Dementia Care Unit**

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

**Hospice**

Current Residents: *0*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *32*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *1*  
Have Mobility Need: *0* Have Physical Disability: *7*

**Inspections / Reviews**

**05/12/2025 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/07/2025*

06/10/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/27/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 06/15/2025

06/20/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/27/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 06/27/2025

07/17/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/27/2025

Reviewer: [REDACTED]

Follow-Up Type: Exception

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home 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 personal care home.

Description of Violation

On 5/12/2025 the home's current violation report, dated 6/26/2024, was not posted in a conspicuous and public place in the home.

Plan of Correction

Do Not Accept (█ - 06/10/2025)

-The violation report was immediately printed and posted in a clearly visible location near the main entrance on 5/14/2025.

-Administrator or designee will make sure that the survey is available to the residents at all times.

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

Update: 06/10/2025

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction

Accept (█ - 06/20/2025)

-The violation report was immediately printed and posted in a clearly visible location near the main entrance on 5/14/2025.

- The report was also posted on the 2nd floor bulletin board.

-Starting 06/10/25, Administrator or designee will do daily checks for 4 weeks following weekly checks to confirm that the report is available to view.

-The administrator or designee will review the postings weekly and document the review in the facility's compliance log.

- Any missing or outdated documents will be replaced within 24 hours.

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

Evidence of Completion

Implemented (█ - 07/17/2025)

See attached.

17 - Record Confidentiality

2. Requirements

2600.

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

Description of Violation

On 5/12/2025, at 10:13 am, the resident lab test request slip binder was unlocked, unattended, and accessible in the Lab Supplies, Lab Pickup and Nursing Supplies closet on the 2nd floor of the home.

17 - Record Confidentiality (continued)

Plan of Correction

Accept (█) - 06/10/2025)

- New Lock and key on the door were installed on 05/15/25.
- Administrator along with the Resident care will ensure that residents records are not accessible to anyone other than residents and assigned designee.
- In addition, new policy was implemented requiring all sensitive resident documents to be stored in locked, staff-only areas.
- Weekly audits of storage areas will be conducted for the next 90 days to ensure compliance following on ongoing basis.

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

Evidence of Completion

Implemented (█) - 07/17/2025)

See attached.

63a - First Aid/CPR Training

3. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On the following dates and times, residents were present in the home. During these times no staff persons were present in the home who were certified in first aid, obstructed airway techniques and CPR:

- 4/27/2025, 10:00 pm to 4/28/2025, 6:00 am
- 4/28/2025 10:00 pm to 4/29/2025 6:00 am
- 4/29/2025 5:00 pm to 10:00 pm
- 5/1/2025 10:00 pm to 5/2/2025 6:00 am
- 5/2/2025 6:30 pm to 5/3/2025 6:00 am
- 5/6/2025 10:00 pm to 5/7/2025 8:30 am

Repeat violation: 6/11/2024 et al

Plan of Correction

Accept (█) - 06/10/2025)

- Immediate review of staff schedules were conducted on 05/13/25.
- Staff without current certifications were removed from unsupervised shifts until certified.
- Emergency coverage was arranged to ensure compliance while staff completed training.
- Staff needs to present proof of their certification by 06/20/25
- Administrator, Resident care and Business office director has a copy of the tracker.
- Audit of the tracker every 30 days.
- A monthly audit of staff certifications and shift coverage will be conducted every 30 days and then on ongoing basis.

All Direct staff must have current CPR and first Aid certification before permitted to work.

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

63a - First Aid/CPR Training (continued)

Evidence of Completion

Implemented ( ) - 07/17/2025

See attached.

65e - 12 Hours Annual Training

4. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A received 0 hours of annual training in training year 2024.

Plan of Correction

Accept ( ) - 06/10/2025

Direct Staff A is no longer employed with the company.

Action is to immediately schedule and complete the required annual training withing 30 days, no later than 06/27/25. The training will include all mandatory topics as outlined by DHS regulations.

Attached is the Annual training tracker.

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

Evidence of Completion

Implemented ( ) - 07/17/2025

Training has been scheduled. Employees have been notified. See attached.

65g - Annual Training Content

5. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person B did not receive training in 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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, or, new population groups that are being served at the home that were not previously served, if applicable during training year 2024.

Staff person C did not receive training in 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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, or, new population groups that are being served at the home that were not previously

65g - Annual Training Content (continued)

served, if applicable during training year 2024.

Plan of Correction

Accept (█) - 06/10/2025

Staff Persons B and C were immediately scheduled to complete all required training modules by 06/28/25.

On 05/14/25 Maintenance Director received █ certification from the fire safety expert.

Training will be conducted by a certified fire safety expert and included all required topics by 06/28/25.

In addition, documentation of completed training was added to each staff member's personnel file.

Administrator implemented training calendar and tracking system to ensure timely completion of all required annual trainings.

A designated staff member was assigned to monitor training compliance and coordinate with certified trainers.

All new hires will be required to complete mandatory fire safety training on the day of the orientation.

Licensee's Proposed Overall Completion Date: 06/25/2025

Evidence of Completion

Not Implemented (█) - 07/17/2025

See attached.

Update: 07/17/2025

Training on OAPSA and fire safety not completed.

66b - Training Plan Content

6. Requirements

2600.

66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

Description of Violation

The home does not have a staff training plan for Direct Care Staff required training.

Plan of Correction

Accept (█) - 06/10/2025

Training plan for Direct Care Staff was developed and implemented on 05/14/25.

Annual training has been scheduled for the following:

05/21/25- Resident rights and Fall Prevention (Completed and documented)

06/17/25 at 1 pm- Fire safety

07/16/25 at 1 pm- Emergency preparedness.

08/20/25 at 1 pm The older adult protective services

09/17/25at 1 pm New Population Group that are being served at home.

10/15/25 at 1 pm- Abuse and Neglect.

11/19/25 at 1 pm- Medication Managment

Annual training schedule has been sent to the employees.

Attached is the training tracker.

-Every new hire will receive an adequate training at the new employee orientation, following annual training.

Training tracker will be put in each employee file.

-Training Binder will locate in Administrators office.

-Administrator will audit all the employees training every 30 days and ensure that the training is in compliance.

66b - Training Plan Content (continued)

Please, see attached documents.

Licensee's Proposed Overall Completion Date: 06/13/2025

Evidence of Completion

Implemented ( ) - 07/17/2025

Annual training tracker has been implemented.

85d - Trash Receptacles

7. 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 5/12/2025 at 10:29 am there was a partially full, uncovered, trash can in the main kitchen.

Plan of Correction

Accept ( ) - 06/10/2025

-All uncovered trash cans in the kitchen and bathroom areas were immediately replaced with covered, pest-resistant containers on 05/12/25.

-Staff were instructed to use only covered receptacles moving forward.

-Dinning Director enforced the new kitchen sanitation checklist, including a line item for covered trash cans.

-Staff were retrained on proper waste management.

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

Evidence of Completion

Implemented ( ) - 07/17/2025

See attached.

86b - Bathroom

8. Requirements

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom in room A105, does not have an operable window or ventilation fan. The ventilation fan is inoperable and there is no window in the bathroom.

Plan of Correction

Accept ( ) - 06/10/2025

The inoperable ventilation fan in Room A105 was inspected by maintenance staff on 05/13/25. The bathroom now has a fully functional mechanical ventilation system.

Administrators along with Maintenance Director will do weekly walk thru the apartment to ensure proper working equipment.

Licensee's Proposed Overall Completion Date: 06/13/2025

Evidence of Completion

Implemented ( ) - 07/17/2025

Maintenance Director did walk thru 06/02, 06/09, 06/16, 06/23 2025.

Scheduled walk thru- 6/30/ 07/07 07/14 07/22 - Ongoing weekly basis.

88a - Surfaces

9. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 5/12/2025, at 10:29 am, there was a large hole in the ceiling of the main kitchen.

Plan of Correction

Do Not Accept ( [redacted] - 06/10/2025)

The repair progress started on 05/09/25. The ceiling was fully repaired on 05/26/25.

Licensee's Proposed Overall Completion Date: 06/13/2025

Update: 06/10/2025

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction

Accept ( [redacted] - 06/20/2025)

The repair progress started on 05/09/25. The ceiling was fully repaired on 05/26/25

-Starting 05/14/25, Maintenance Director and Administrator will conduct 30-day checks and reviews of the building on ongoing basis.

- Any leaks, damaged floors, walls, surfaces will be addressed immediately.

-The administrator will review open maintenance requests weekly in TELS and ensure repairs are completed within 5 days unless otherwise justified.

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

Evidence of Completion

Implemented ( [redacted] - 07/17/2025)

Picture of completed repair was submitted.

103e - Left Overs

10. Requirements

2600.

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

Description of Violation

On 5/12/2025, there was:

- open, unlabeled, undated broccoli salad and salsa in the main kitchen refrigerator.
- open, unlabeled, undated danish in a bag in the walk-in freezer.
- open, unlabeled, undated chocolate chips, ritz cracker crumbs and cobbler topping on the shelf in the dry goods storage area.

Plan of Correction

Accept ( [redacted] - 06/10/2025)

All improperly stored food items were immediately discarded on 5/12/2025.

-The kitchen and dietary staff were verbally re-educated on proper labeling and dating procedures the same day.

-A full inspection of all food storage areas was conducted, and any additional non-compliant items were removed.

103e - Left Overs (continued)

A facility-wide audit of all food storage areas was completed on 05/15/25. The Dining Director will conduct weekly audits of all food storage areas.

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

Evidence of Completion

Not Implemented (█ - 07/17/2025)

See attached.

Update: 07/17/2025

New violation cited at POCV inspection.

103f - Refrigerator/Freezer Temps

11. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 5/12/2025 at 10:31 am, there was no thermometer in the refrigerator in the main kitchen.

Repeat violation: 6/11/2024 et al

Plan of Correction

Accept (█ - 06/10/2025)

A thermometer was installed on 05/12/25. Staff were reminded of temperature monitoring protocols. Dining director or designee person will check daily and ensure the thermometer is placed in the fridge.

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

Evidence of Completion

Implemented (█ - 07/17/2025)

See attached.

103i - Outdated Food

12. Requirements

2600.

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

Description of Violation

On 5/12/2025 at 10:34 am, there was a dented can of sauerkraut, and a dented can of applesauce on the canned goods rack in the dry goods storage area.

Plan of Correction

Do Not Accept (█ - 06/10/2025)

- The dented cans were immediately removed and discarded on 5/12/2025.
- Staff were reminded of the policy to inspect all canned goods for damage before storage and use.
- A full inspection of all canned goods in the facility was conducted on 05/16/25 following monthly audits.

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

Update: 06/10/2025

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

103i - Outdated Food (continued)

Plan of Correction

Accept (█) - 06/20/2025)

- The dented cans were immediately removed and discarded on 5/12/2025.
- Staff were reminded of the policy to inspect all canned goods for damage before storage and use.
- Staff will receive quarterly training on food safety and storage protocols.
- Dining director implemented Weekly dry goods inspection checklist.
- 1st Training was conducted by the Dining Director on 06/12/25. Next training is scheduled for 09/18/25 following quarterly basis.
- Any damaged goods will be logged and reviewed by Dining Director and Administrator during monthly QMPI Meetings on ongoing basis.

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

Evidence of Completion

Implemented (█) - 07/17/2025)

See attached.

132b - Safety Inspection/Fire Drill

13. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection observed by a fire safety expert was conducted on 3/28/2024.

Plan of Correction

Do Not Accept (█) - 06/10/2025)

- A fire safety consultant was contracted to assess the facility and provide a written maximum safe evacuation time on 05/09/25. This assessment was completed on 05/09/25.
- A revised fire drill procedure was implemented to ensure timely and complete evacuation of all residents, including those on the 2nd floor.
- Staff involved in the 10/30/2024 and 4/25/2025 drills were re-trained on emergency evacuation protocols.
- Maintenance Director reviewed all fire drill records from the past 12 months was conducted to identify additional instances of non-compliance.

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

Update: 06/10/2025

This POC appears to be meant for a different violation.

Plan of Correction

Accept (█) - 06/20/2025)

- On 05/09/2025, the facility contracted a certified fire safety expert to conduct a full fire safety inspection and supervised fire drill.
- Documentation of the inspection and drill, including evacuation times and recommendations, has been filed and is available for review.
- The administrator has added the annual fire safety inspection and drill to the facility's compliance calendar.
- Calendar reminder is set on 60 day reminder.
- Calendar invite included Maintenance Director, Administrator and Regional Maintenance Director.
- As of 06/10/25, a reminder system has been implemented to ensure timely scheduling each year.

132b - Safety Inspection/Fire Drill (continued)

-Starting 06/10/25, The administrator will verify completion of the inspection and drill annually and maintain documentation in a designated compliance binder.

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

Evidence of Completion

Implemented ( ) - 07/17/2025)

See attached.

132d - Evacuation

14. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 10/30/2024 at 5:20 am, the evacuation time was 23 minutes, and the residents on the 2nd floor were not evacuated. The home's fire safety inspection letter dated 3/28/2024 indicates a maximum safe evacuation time of 15 minutes.

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills: 4/25/2025, 4:46 am, evacuation time 13 minutes.

Plan of Correction

Do Not Accept ( ) - 06/10/2025)

A certified fire safety expert was contracted on 05/09/25 to assess the facility and provide a written determination of the maximum safe evacuation time. Evacuation Time is 15 minutes.

Staff involved in the 4/25/2025 drill were debriefed and retrained on evacuation procedures on 05/14/25.

This documentation will be reviewed annually and updated as needed by the administrator and the fire safety expert. Please see attached letter.

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

Update: 06/10/2025

This POC appears to be meant for a different violation.

Plan of Correction

Accept ( ) - 06/20/2025)

-On 5/09/2025, the home contracted ( ), a certified fire safety expert unaffiliated with the facility, to conduct a full fire safety inspection.

-A new written designation of a fire-safe area and a maximum evacuation time of 15 minutes was received on 05/25/25.

- Designated fire safe area is Flagpole outside the building. If evacuated thru the Back of the building, fire safe area is located by the Fishpond.

-A follow-up fire drill was conducted on 05/09/2025, with an evacuation time of 3:09 min, within the designated limit.

-Evacuation protocols will be revised to ensure all floors are included in every drill.

-Staff will be assigned specific responsibilities for each floor during drills.

-Targeted drills involving 2nd-floor residents will be conducted by the Maintenance Director every three weeks until compliance is achieved.

## 132d - Evacuation (continued)

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

Evidence of Completion

Implemented (█) - 07/17/2025)

See attached.

## 141a 1-10 Medical Evaluation Information

## 15. 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

Resident 1's medical evaluation, dated █, did not include body positioning and movement stimulation for residents, if appropriate, health status, or mobility assessment, updated annually or at the Department's request.

Resident 2's medical evaluation, dated █ did not include Allergies or Body positioning and movement stimulation for residents, if appropriate.

Resident 3's medical evaluation, dated █ did not include Allergies

## Plan of Correction

Accept (█) - 06/10/2025)

-All three residents received updated medical evaluations by a licensed healthcare professional on May 30th, 2025.

-A monthly audit of resident medical evaluations will be conducted by the Care -Director or designee following on the ongoing basis.

-DME tracker was implemented to ensure all document are current.

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

Evidence of Completion

Not Implemented (█) - 07/17/2025)

See attached.

Update: 07/17/2025

Related violation cited.

## 141b1 - Annual Medical Evaluation

16. Requirements

2600.

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

Description of Violation

Resident 2's most recent medical evaluation was completed on [REDACTED]. The resident's previous medical evaluation was completed on [REDACTED]. As of 5/12/2025, a current medical evaluation has not been completed.

Resident 3's most recent medical evaluation was completed on [REDACTED]. The resident's previous medical evaluation was completed on [REDACTED].

Repeat violation: 6/11/2024 et al

Plan of Correction

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

-Resident 2 will receive an updated medical evaluation by June 25th, 2025.

-Resident 3's evaluation schedule will be adjusted to ensure future evaluations occur within 12 months.

-A tracking log will be implemented to monitor due dates for all resident medical evaluations.

-Alerts will be set 30 days in advance of due dates to ensure timely completion.

Licensee's Proposed Overall Completion Date: 06/25/2025

Evidence of Completion

Not Implemented ( [REDACTED] - 07/17/2025)

See attached.

Update: 07/17/2025

New violation cited.

181e - Capable to Self Administer

17. Requirements

2600.

181.e. To be considered capable to self-administer medications, a resident shall:

1. Be able to recognize and distinguish his medication.
2. Know how much medication is to be taken.
3. Know when medication is to be taken.

Description of Violation

Resident 4 self-administers medications to include Lasix Oral Tablet 40 mg. On 5/13/2025, the resident was unable to indicate how much medication they take.

Plan of Correction

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

-Resident care director did a self admin evaluation on 05/13/25. Resident passed the test.

-Resident was capable of indicating of how much medication they are taking. - Resident care Director will retest the resident on quarterly basis starting 05/13/25.

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

Evidence of Completion

Implemented ( [REDACTED] - 07/17/2025)

Resident is set to be reevaluated on 08/13/25.

## 181f - Record of Medication

**18. 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 5/13/2025, resident 4's record did not include a current list of medications. The list in the resident's record did not include resident's prescribed medication: Multaq 400 mg, take one tablet by mouth 2 times a day before meals.*

**Plan of Correction**

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

*-On 05/13/25 RCD called the physician and verified the order and placed it on the medication record.*

*-Resident Care Director will keep the accurate record of current list of medications for all the residents.*

*-Resident Care Director will audit the records and resident's med cabinets every week for 90 days, following monthly audit on ongoing basis.*

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

**Evidence of Completion**

Implemented ( [REDACTED] - 07/17/2025)

*See attached.*

## 182b - Prescription Medication

**19. Requirements**

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

**Description of Violation**

*Staff person D completed the paper version of the medication administration certification training on [REDACTED] while employed at another home. As of 1/1/24 medication administration certification training is to be completed via the online training platform. The home does not have verification of staff person D's online training certification nor does the home have documentation of any practicum observations completed since [REDACTED] which is prior to the staff persons employment at the home. Staff Person D does not meet the requirements to administer medications to residents in the home, however, Staff person D, administered medications to residents on the following dates and times:*

*Medications administered to resident 5:*

- *Amlodipine Besylate Oral Tablet 5 mg, Cholecalciferol Oral Tablet 25 MCG, Furosemide Oral Tablet 10 mg, on 5/10/2025 and 5/11/2025 at 8 am*

*Medications administered to resident 6:*

- *Acidophilus Oral Capsule 100 mg, Bumax Oral Tablet .5 mg, BusPIRone HCL oral tablet 10 mg, Lorazepam*

182b - Prescription Medication (continued)

Oral Tablet .5 mg, on 5/10/2025 and 5/11/2025 at 8 am

Staff person E completed the paper version of the medication administration certification training on [REDACTED] while employed at the home. As of 1/1/24 medication administration certification training is to be completed via the online training platform. The home does not have verification of staff person E's online training certification nor does the home have documentation of any practicum observations completed since the initial training completed on [REDACTED] Staff Person E does not meet the requirements to administer medications to residents in the home, however, Staff person E, administered medications to residents on the following dates:

Medications administered to resident 5:

- Amlodipine Besylate Oral Tablet 5 mg, Cholecalciferol Oral Tablet 25 MCG, Furosemide Oral Tablet 10 mg, on 5/3/2025 at 8 am

Medications administered to resident 6:

- Acidophilus Oral Capsule 100 mg, Bumax Oral Tablet .5 mg, BusPIRone HCL oral tablet 10 mg, Lorazepam Oral Tablet .5 mg, on 5/3/2025 at 8 am

Plan of Correction

Do Not Accept [REDACTED] - 06/10/2025)

- Staff Person D was immediately removed from medication administration duties on 05/12/2025.
- Staff person immediately printed their med tech summary to comply with the policy.
- Staff E resigned on 05/08/25.
- On 05/14/25 Care director and Assistant care audited all the care staff certifications.
- All medication passes conducted by Staff Persons D and E on the identified dates were reviewed by the RCD. No medication errors or adverse effects were identified.
- Designee person will do 30-day audits on ongoing basis.

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

Update: 06/10/2025

What will the designee be auditing?

Plan of Correction

Accept [REDACTED] - 06/20/2025)

- Staff Person D was immediately removed from medication administration duties on 05/12/2025.
- Staff person immediately printed their med tech summary to comply with the policy.
- Staff E resigned on [REDACTED]
- On 05/14/25 Care director and Assistant care audited all the care staff certifications.
- All medication passes conducted by Staff Persons D and E on the identified dates were reviewed by the RCD. No medication errors or adverse effects were identified.
- Designee person will be auditing employee Online Med Tech Certification and Observation Log every 30-day following on ongoing basis.
- A quarterly compliance review will be implemented thereafter.
- Any discrepancies will be reported directly to the Administrator and corrective action will be taken immediately.

182b - Prescription Medication (continued)

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

Evidence of Completion

Implemented ( ) - 07/17/2025

The user report for person D was previously submitted. That staff person was terminated. Assistant RCD has reviewed the all-staff online Med tech certification. ALL is in compliance. Please, see the tracker.

183d - Prescription Current

20. 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 5/13/2025, Benzonatrate 20 mg prescribed for individual 6, was in the home's medication cart; however, the medication was discontinued on 3/19/2025.

On 5/13/2025, Lantus Solostar Insulin Pen prescribed for individual 7, was in the home's medication refrigerator; however, the resident passed away on [REDACTED]

Plan of Correction

Accept ( ) - 06/10/2025

- On 05/13/2025, the Medication Technician removed and properly disposed of: Benzonatate 20 mg for Individual #6 and Lantus Solostar Insulin Pen for Individual #7.
- Disposal was documented in the Med discontinuation log and Resident chart.
- A full audit of the medication cart and refrigerator was conducted on 5/14/2025 to ensure no other discontinued or unassigned medications were present.
- Weekly audits of all medication storage areas by the Resident Care Director.
- Immediate removal and documentation of any discontinued or unassigned medications.
- On 5/16/2025 Staff were retrained regarding proper procedures for medication discontinuation and post-resident discharge medication handling.
- Resident care director as well as Executive director drafted a letter to the residents and families to ensure that residents comply with the policies.

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

Evidence of Completion

Not Implemented ( ) - 07/17/2025

See attached.

Update: 07/17/2025

Training not completed.

185a - Implement Storage Procedures

21. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident 5 is prescribed Dulcolax rectal suppository 10 mg and Milk of magnesia oral suspension 400 mg/5ml

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

as needed. On 5/13/2025 these medication(s) were not available in the home.

Resident 8 is prescribed Immodium A-D Oral tablet 2 mg and Milk of magnesia oral suspension 400 mg/5ml as needed. On 5/13/2025 these medication(s) were not available in the home.

Repeat violation: 6/11/2024 et al

**Plan of Correction****Do Not Accept ( ) - 06/10/2025)**

-Medication admin record was reviewed for the last 30 day and revealed that resident did not take prn's medication.

On 05/13 Physician ordered to discontinue Meds for non-use.

By 06/14/2025, all medication administration staff will be trained on:

- Procedures for verifying PRN medication availability.
- Steps to take when a medication is missing or low in stock.
- Documentation and communication protocols with the pharmacy.
- Staff training on procedure to be continue every 60 days on ongoing basis.

**Licensee's Proposed Overall Completion Date: 06/14/2025**

**Update: 06/10/2025**

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

**Plan of Correction****Accept ( ) - 06/20/2025)**

-Medication admin record was reviewed for the last 30 day and revealed that resident did not take prn's medication.

On 05/13 Physician ordered to discontinue Meds for non-use.

By 06/16/2025, all medication administration staff will be trained on:

- Procedures for verifying PRN medication availability.
- Steps to take when a medication is missing or low in stock.
- Documentation and communication protocols with the pharmacy.
- Staff training on procedure to be continue every 60 days on ongoing basis by the RCD and The Assistant Care Director.
- Starting 06/10/25 The Administrator or designee will conduct weekly audits for four weeks of medication availability following monthly on ongoing basis.
- A monthly review of medication orders and refill schedules will be conducted by the Resident care Director along with Assistant Care to prevent future lapses.
- Any missing medications will be documented and addressed within 24 hours.

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

**Evidence of Completion****Not Implemented ( ) - 07/17/2025)**

See attached.

**Update: 07/17/2025**

Training not completed.

**186a - Authorized Prescriber**

**22. Requirements**

2600.

186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

**Description of Violation**

**Withdrawn ( [REDACTED] - 06/10/2025)**

*On 5/13/2025 resident 6's current medication orders included a prescription for Loperamide HCL. However, this medication order was discontinued on 5/6/2025.*

**190b - Insulin Injections**

**23. Requirements**

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

**Description of Violation**

*On 4/25/2025, 4/26/2025 and 4/28/2025, at 4pm, 8 pm an 9 pm, staff person D, who has not successfully completed the Department-approved medications administration course, administered insulin to resident 7.*

**Plan of Correction**

**Do Not Accept ( [REDACTED] - 06/10/2025)**

- Staff Person D was immediately removed from all medication administration duties for insulin injections.*
- The Administrator conducted a full review of insulin administration records for Resident #7.*
- The Administrator conducted a full review of insulin administration records for all the residents who have diabetes. No adverse effects or medication errors were identified.*
- Reminders given 60 days prior their license expiration date.*
- Staff with expired certification will not be put on the schedule.*

**Licensee's Proposed Overall Completion Date: 06/10/2025**

**Update: 06/10/2025**

*Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.*

*This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.*

**Plan of Correction**

**Accept ( [REDACTED] - 06/20/2025)**

- Staff Person D was immediately removed from all medication administration duties for insulin injections.*
- The Administrator conducted a full review of insulin administration records for Resident #7.*
- The Administrator conducted a full review of insulin administration records for all the residents who have diabetes. No adverse effects or medication errors were identified.*
- Starting 05/14/25, RCD and ARCD will give 60-day reminders prior staff license expiration date.*
- Staff with expired or no valid certification will not be put on the schedule.*
- Resident Care Director with Administrator supervision will conduct monthly audit of certification log starting 05/14/25.*
- Starting 06/10/25, Administrator will conduct weekly audits of medication administration records for the next 90 days.*
- Ongoing quarterly audits will be implemented thereafter.*
- Any discrepancies will be reported directly to the Administrator.*

190b - Insulin Injections (continued)

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

Evidence of Completion

Implemented ( ) - 07/17/2025

See attached.

CPR tracker includes all the other certifications and due dates.

227e - Self Administer Medication

24. Requirements

2600.

227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident 9's assessment, dated ( ), does not address the resident's ability to self-administer medications.

Plan of Correction

Do Not Accept ( ) - 06/10/2025

-The residents support plan states that the resident is independent with the medication management.

-Resident Care Director and the Administrator will implement Addition verbiage added to the support plan for clarification.

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

Update: 06/10/2025

The attached document is not the one that was presented at the time of the inspection. Please provide a plan of correction for this violation.

Plan of Correction

Accept ( ) - 06/20/2025

-Administrator had a qualified medical professional assess the resident ability to self-administer medications on ( ) following self-administrating assessment on ( ) that states that resident is able to independently self-administrate medication.

- Starting 06/10/25 Resident Care Director will conduct weekly audit of Support plans for 4 weeks of Residents who self-medicate to make sure that support plan coordinates with the self-medication evaluation results.

- Starting 06/10/25, Resident care Director and Assistant Care Director will use the proper verbiage including, self-administers medications, requires reminders, or needs full medication administration

-Resident Care Director and the Administrator will implement Additional verbiage added to the support plan for clarification.

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

Evidence of Completion

Not Implemented ( ) - 07/17/2025

See attached. Support plan was previously submitted.

Update: 07/17/2025

Audit not completed.

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 [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

Plan of Correction

Do Not Accept ([redacted] - 06/10/2025)

On 06/04/25 Resident care director met with the resident to sign the support plan.

Action: Designee will confirm of resident participation during their evaluation on ongoing basis. If resident cannot attend, designee will note the absence and the reason for the absence.

Licensee's Proposed Overall Completion Date: 06/18/2025

Update: 06/10/2025

Please indicate any additional steps/actions that will be put into place to monitor or audit for ongoing compliance.

This could be specific audits, reviews, spot checks, etc. Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Plan of Correction

Accept ([redacted] - 06/20/2025)

On 06/04/25 Resident care director met with the resident to sign the support plan.

-A copy of the signed plan has been placed in the resident's file.

- Administrator and Resident Care Director will confirm of resident participation during their evaluation on ongoing basis. If resident cannot attend, designee will note the absence and the reason for the absence.

-On 06/10/25, RCD and ARCD implemented A Support Plan Completion Checklist to ensure all required elements, including resident signatures, are completed before finalization.

- The Administrator or designee will review all new and updated support plans weekly for 4 weeks following quarterly audits to ensure completeness, including signatures.

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

Evidence of Completion

Not Implemented ([redacted] - 07/17/2025)

See attached.

Update: 07/17/2025

Audit not completed.