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

September 3, 2025

[redacted], OWNER
WALDEN CARE LLC
325 NORTH BROADWAY
WIND GAP, PA, 18091

RE: WALDEN III SENIOR LIVING COMMUNITY
325 NORTH BROADWAY
WIND GAP, PA, 18091
LICENSE/COC#: 23072

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/14/2025 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: *WALDEN III SENIOR LIVING COMMUNITY* **License #**: *23072* **License Expiration**: *05/02/2026*

Address: *325 NORTH BROADWAY, WIND GAP, PA 18091*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *WALDEN CARE LLC*

Address: *325 NORTH BROADWAY, WIND GAP, PA, 18091*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/28/1994* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *13* **Total Daily Staff**: *61* **Waking Staff**: *46*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/14/2025*

Inspection Dates and Department Representative

05/14/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *77* **Residents Served**: *46*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

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

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

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

05/14/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/15/2025*

06/30/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/20/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/07/2025*

Inspections / Reviews *(continued)*

07/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/20/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/20/2025*

09/03/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/20/2025*

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

25b - Contract Signatures

1. Requirements

2600.
25.b. 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.

Description of Violation

The resident-home contract, dated [redacted], for resident #1, and the resident-home contract, dated [redacted], for resident # 2 were not signed by the resident.

Plan of Correction ***Accept ([redacted] - 07/14/2025)***

How [redacted] happened:
Resident # 1 was admitted into Walden by [redacted] and due to this [redacted] is unable to sign. [redacted] and POA signed the contract for [redacted] admission. The resident's POA failed to write POA after [redacted] name. Resident # 2 was admitted into Walden by [redacted] and [redacted] is also [redacted] POA. Neither resident # 1 and # 2 are capable of signing their name.

Plan of correction:
On 05/17/2025, the administrator obtained the POA documents from both families. The administrator had both resident #1 and #2 POA's add the letters POA to their contracts. "An addendum line was added to the current contracts that if the resident is unable to sign the contract the reason why it is not signed, if refused to sign or unable to sign due to illness, stroke, etc."

Moving forward:
On 05/17/2025, the administrator and the assistant administrator will audit the client files to ensure all the contracts are signed accordingly. If the resident is unable to sign, the POA will provide a copy of their POA legal documents. Administrator has changed the resident contract to reflect the following:

"An addendum line was added to the current contracts that if the resident is unable to sign the contract the reason why it is not signed, if refused to sign or unable to sign due to illness, stroke, etc."

Licensee's Proposed Overall Completion Date: *07/06/2025*

Implemented ([redacted] - 08/12/2025)

29a SOPb1- Hospice Care: Doctor Certification

3. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
1. A physician, who is not an employee or contractor of the home, has certified in writing that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill.

Description of Violation

Staff indicated that Resident 3 was not evacuated during fire drills completed in January, February, and March 2025,

29a SOPb1- Hospice Care: Doctor Certification (continued)

due to being on Hospice. There is no documentation from a physician that the resident is actively dying and may suffer bodily injury or hastened death if they participate in the fire drills.

Plan of Correction ***Accept (- 07/14/2025)***

How this happened:
On 05/14/2025 the surveyor discover an error on the administrator. The administrator had no obtained Resident #3 is actively dying. It was an oversight on the administrator to download the letter from Dr and the Care Team for resident #3.

Plan of correction:
On 05/14/2025, the administrator downloaded the document from Dr and the Care team. The administrator gave it to the Surveyor for review and the surveyor rejected the document, stated it had to be more specific. The administrator notified the Care Team Hospice and Dr. and asked for the required document. "All residents will be evacuated unless a written letter from their physician is on hand indicating that they are actively dying and participation in fire drills may hasten death. All letters must be specific to the resident and signed by the physician."

Moving forward:
Starting 05/15/2025, the administrator and the assistant administrator have begun monthly audits of the hospice residents. A letter from Dr. and the Care Team Hospice has been submitted and placed in the residents file.

"All residents will be evacuated unless a written letter from their physician is on hand indicating that they are actively dying and participation in fire drills may hasten death. All letters must be specific to the resident and signed by the physician."

Licensee's Proposed Overall Completion Date: *07/06/2025*

Implemented (- 08/12/2025)

29a SOPb2 - Hospice Care: Informed Consent

4. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
2. The resident, the resident's power of attorney for health care, the resident's legal guardian or the resident's health care representative has provided written informed consent that the person is not to evacuate in a fire drill.

Description of Violation

Resident 3 was not evacuated during fire drills completed 1/10/25, 2/5/25, and 3/17/25 because they are on hospice. There is no written informed consent from the resident or power of attorney not to evacuate.

Plan of Correction ***Accept (- 07/14/2025)***

How did this happen:
On 05/15/2025 the surveyor discovered the residents POA does not have an "informed consent" The Durable Medical Power of Attorney Document does not include specifically that identifies evacuation.

Plan of correction:
On 05/15/2025 the administrator spoke with resident #3 POA and asked for clarification from the POA if they

29a SOPb2 - Hospice Care: Informed Consent (continued)

want their loved one to evacuate during a fire drill. A document was drafted and placed in the chart.

Moving forward:
On 05/15/2025, the administrator and assistant administrator conducted an audit of all residents files to ensure the Health Care POA documents contain the clause that, they are aware of the monthly fire drills and whether they wish their loved one to evacuate during the drill if they are on hospice.

"ALL residents will be evacuated for ALL fire drills unless written certification satisfying regulation 29a SOPb1 are satisfied and written informed consent is received from the resident, guardian and/or POA."

Licensee's Proposed Overall Completion Date: *07/06/2025*

Implemented ([redacted] - 08/12/2025)

29a SOPb4 - Hospice Care: Inform Non-Participating

5. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
4. During a fire drill, the one designated person at the home who has knowledge in advance of the fire drill is to immediately upon setting off the fire alarm to begin the fire drill, go to the room of the resident who meets the conditions of paragraphs (1)—(3), and notify the affected resident and any staff person who attempts to evacuate the resident, that this is a fire drill and the resident is not to be evacuated.

Description of Violation

Resident 3 was not evacuated during fire drills completed 1/10/25, 2/5/25, and 3/17/25 because they are on hospice. There is no staff member going to the resident's room to inform staff that the alarm is only a drill and the resident does not need to be evacuated.

Plan of Correction ***Directed ([redacted] - 07/14/2025)***

How this happened:
On 05/14/2025 The surveyor discovered that Resident #3 did not evacuate during the fire drills on 1/10/25, 2/5/25, and 3/17/25, due to being on hospice. Staff goes to the room of the resident in advance of the pending drill, but does not not stay with the resident.

Plan of correction:
On 05/15/2025 the administrator drafted a new evacuation memo for all staff that there will be a designated staff person dedicated to informing the resident that they will not need to evacuate and the dedicated staff person will be sitting with the resident on hospice, if they are unable to evacuate. In this scenario it is resident #3.

Moving forward:
On 05/15/2025, the administrator has added the memo to the Walden III Policy Manual. It has been adopted as a new policy and will be adhered to in all future fire drills and all staff has been trained on this policy.

"It has been added that they shall proceed with the evacuation of ALL residents during a fire drill unless the 1 staff person with knowledge that it is a drill goes to the room and informs staff not to evacuate the resident. All other stipulations from the Statement of Policy for this regulation should also be fully followed."

29a SOPb4 - Hospice Care: Inform Non-Participating (continued)

Proposed Overall Completion Date: 07/06/2025

Directed: In addition to the above plan of Correction, staff will initiate requirements of 29a-bi, and 29a-bii once the requirements of 29a-b4 are satisfied.

Directed Completion Date: *07/18/2025*

Implemented (- 08/12/2025)

51 - Criminal Background Check

6. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Criminal background checks for staff persons B and C were not completed in accordance with the Older Adult Protective Services Act.

Plan of Correction ***Accept (- 07/14/2025)***

How this happened:
On 05/15/2025 the surveyor discovered and error with Staff person B and C personnel files. Both staff were [redacted] students, performing ancillary positions with in the kitchen. They both were [redacted] when hired and the administrator was under the assumption that [redacted] students were exempt from the state police background checks. The administrator was wrong.

Plan of correction:
On 05/14/2025, the administrator immediately ran the criminal background checks on staff person B and C. The administrator handed the documents to the surveyor. Staff person B was still [redacted] at the time of the survey. Staff person C graduated last year. A copy of the criminal background check was placed in their respective files.

Moving forward:
On 05/15/2025, the administrator and the secretary started an audit of the personnel files to ensure all documents are included in their respective files.

To prevent this from occurring again in the future, a checklist has been added to the employee file there is a checklist that has to completed when each step is completed and documentation is provided.

Licensee's Proposed Overall Completion Date: *07/06/2025*

Implemented (- 08/12/2025)

65d - Initial Direct Care Training

8. Requirements

2600.

65d - Initial Direct Care Training *(continued)*

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - xi. Care and needs of residents with special emphasis on the residents being served in the home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. Infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person C, hired on [redacted] began providing unsupervised ADL services on [redacted] However, the staff person did not complete the following initial direct care staff person training: Safe management techniques, The normal aging-cognitive, psychological and functional abilities of individuals who are older., Implementation of the initial assessment, annual assessment and support plan., Nutrition, food handling and sanitation., Recreation, socialization, community resources, social services and activities in the community, Gerontology. Care and needs of residents with special emphasis on the residents being served in the home. Safety management and hazard prevention. Universal precautions, Infection control. Care for individuals with mobility needs.

Plan of Correction ***Accept ([redacted] - 06/28/2025)***

How this happened:
Staff person C was hired as while still a student [redacted] The administrator gave [redacted] the initial direct care training upon hire. Then staff person C wanted to pick up more hours and completed the Direct Care Course. The Direct Care Course Certificate was placed in [redacted] file.

Plan of correction:
On 05/15/2025, the administrator and the secretary immediately pulled all the personnel files and audited them to ensure all the required training are in the file. The document required for the initial direct care training is located within staff person C file. I've included a copy.

Moving forward:
On 05/15/29025, the administrator and secretary began an audit of all personnel files to ensure they are complete with the required documents and training forms. An audit will the be done monthly of the files to stay on top of the files to ensure this does not happen again.

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

Implemented ([redacted] - 08/12/2025)

65g - Annual Training Content

9. 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:
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Staff person D did not receive training in the Older Adult Protective Services Act during the 2024 training year.

Repeat Violation: 7/9/2024.

Plan of Correction ***Accept (- 06/25/2025)***

How did this happen:
On 05/14/2025 the annual surveyor discover the Staff person D was missing OAPSA training. Staff person D was out on sick leave when the administrator conducted the training on OAPSA. When returned the administrator overlooked the required training document and failed to retrain staff person D on the OAPSA.

Plan of Correction:
On 05/16/2025 Staff person D was immediately retrained in the Older Adult Protective Services Act. The signed document was placed in staff person D's file and in the DHS Manual.

Moving forward:
On 05/16/2025, the administrator will conduct monthly audits on all the personnel files to ensure all the required documents are in the personnel file and placed in the DHS Manual of required documents.

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

Implemented (- 08/12/2025)

82a - Poisonous Materials

10. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

A white spray bottle with the words Fabuloso written on it with black marker was hanging on the housekeeper cart in the hallway. The bottle did not include original product labeling.

Plan of Correction ***Accept (- 06/25/2025)***

How this happened:
On 05/14/2025 during the annual survey it was discovered that a housekeeper had placed a spray bottle on cart that had Fabuloso on it. The spray bottle was only marked with the word Fabuloso. It was not in its original container. Our product comes in large gallon containers and the housekeeper, didn't realize it was in violation the DHS regulations. The administrator did not look at the housekeeping carts to be sure there is no contraband on the carts or that the housekeeper are using contraband.

82a - Poisonous Materials (continued)

Plan of correction:
on 05/15/2025, the administrator went through the housekeeping closet and removed all unlabeled bottles. A copy of the regulation was posted in the closet and all the housekeepers were given a copy as well. A meeting was held with the housekeepers and kitchen staff that all cleaning products have to be kept in their original container.

Moving forward:
On 05/15/2025 the administrator and assistant administrator will conduct a weekly check of the cleaning carts for unmarked bottles of chemicals. This will ensure all cleaning products are kept in their original marked containers.

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

Implemented ([redacted] - 08/12/2025)

85a - Sanitary Conditions

11. Requirements

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

Description of Violation

At 9:12a.m., feces were located on the toilet seat in the shower room located by room 113. At 4:15p.m. there was a strong smell of urine in room 112.

Plan of Correction ***Accept ([redacted] - 06/25/2025)***

How this happened:
At 9:15 am, on 05/14/2025 the surveyor was conducting a building check and discovered had walked in and found the feces on the toilet. The housekeeper had not finished with cleaning the bathroom. [redacted] was in process of doing so. Room 112, the resident is incontinent. [redacted] chair had an odor and believe it's urine. Room 112 was either wet or had just voided.

Plan of correction:
On 05/14/2025 The surveyor asked the administrator to accompany [redacted] to room 112, the administrator could not smell the odor. The administrator asked the assistant administrator to go check out the odor. The assistant administrator thinks it maybe the chair. The administrator had housekeeping shampoo the chair. On 05/16/2025, the assistant administrator rechecked the room and the odor seems to have dissipated.

Moving forward:
on 05/16/2025 the assistant administrator and administrator conducted a room audit to check for odors. The rug and chair will be shampooed shampooed on a monthly basis.

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

Implemented ([redacted] - 08/12/2025)

85d - Trash Receptacles

12. Requirements

2600.

85d - Trash Receptacles *(continued)*

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

At approximately 9:15 a.m. there were two uncovered and unattended trash cans in the shared shower rooms that are located near rooms 107 and 113.

Plan of Correction ***Accept (- 07/14/2025)***

How this happened:
On 05/14/25 the housekeeping had already started their assignments. Right after breakfast they are to collect all trash from the rooms and the tubs rooms, when the surveyor walked in the tub rooms. These two cans have the flip lid on them and the housekeeper was just getting started.

Plan of correction:
On 05/15/2025, The housekeeping department have been retrained to empty the trash receptacle and replace with a clean bag immediately.
Housekeeping staff were retrained on proper removal of trash from all rooms and replacement of fresh trash bags, immediately after removal.

Moving forward:
on 05/15/2025 the administrator met with the housekeepers and explained the 0regulation and the corrections, required.

On 05/15/2025 The housekeepers were retrained in sanitary conditions and asked when emptying these trash cans to please replace the trash bag and lid immediately after emptying. The administrator is auditing monthly.

Licensee's Proposed Overall Completion Date: *07/06/2025*

Implemented (- 08/12/2025)

85e - Trash Outside Home

13. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 9:10 a.m., two exterior filled garbage cans were located outside of the kitchen exit door, and did not have lids to prevent preparation of insects and rodents.

Plan of Correction ***Accept (- 06/25/2025)***

How this happened:
On 05/15/2025 the surveyor was conducting the building inspection, the surveyor discovered two trash cans outside uncovered. One can belongs in the kitchen and the other was placed outside to the left of the door for recycling cans. The chef had just finished with this kitchen can and placed it outside to remove the bag and empty it to put in the dumpster.

Plan of correction:
The recycling can was removed and all recycling will be walked out to the recycling dumpster. The inside garbage

85e - Trash Outside Home (continued)

can was replaced with a lid also, when not in use.

Moving forward:
on 05/15/2025 The administrator conducted an short audit of the exterior trash receptacles and replaced any without lids. This audit will be conducted monthly by the maintenance department.

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

Implemented (- 08/12/2025)

91 - Telephone Numbers

14. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the landline telephone in room 132.

Repeat Violation: 7/9/2024.

Plan of Correction ***Accept (- 06/25/2025)***

How this happened:
On 05/14/2025 the surveyor was conducting room checks and found the resident in 132 has a landline. Room 132's handset was replaced recently with a phone with bigger numbers, making it easier to read. The staff and administrator was unaware of the new handset. It was an oversight when had replaced the handset with a new one.

Plan of correction:
On 05/14/2025, the assistant replaced the emergency number sticker on the new handset.

Moving forward:
on 05/15/2025 the assistant conducted an audit of all rooms to locate any other landline telephones. None were found. The assistant will conduct audit monthly to ensure this does not happen again.

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

Implemented (- 08/12/2025)

102i - Soap Dispenser

15. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

At 9:20 a.m., there was an unlabeled used bar of soap in the shared bathroom on 1st floor.

102i - Soap Dispenser *(continued)*

Plan of Correction ***Accept (- 06/25/2025)***

How this happened:
On 05/14/2025, an employee used the public restroom and realized there was no soap dispenser. It was missing from the bathroom. was unaware the bar soap is against the regulation unless it is individually labeled for each resident. put a bar of hand soap in the restroom.

Plan of correction:
On 05/16/2025 The bar of hand soap was removed and a soap dispenser was replaced in the public restroom. The employee was educated on the use of bar soap.

Moving forward:
On 05/16/2025, the head housekeeper will conduct daily audit of the public restroom and report once weekly to the administrator the finding of the audit. The administrator has removed all bar soap from the housekeeping closet and disposed of it. Moving forward there will only be liquid hand soap allowed in the building.

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

Implemented (- 08/12/2025)

103e - Left Overs

16. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At 3:35p.m. there was an unlabeled, undated container of cut up strawberries in the white refrigerator in the kitchen.

Plan of Correction ***Accept (- 06/25/2025)***

How this happened:
On 05/14/2025 during the annual survey the surveyor discovered an unlabeled container in the refrigerator. An employee brought in their supper and hadn't finished it. They placed their unlabeled container in the refrigerator that is used mainly for the storage of juice. She overlooked writing the name and date of lunch. The surveyor then examined the refrigerators for temperatures and found the employees left over lunch.

Plan of correction:
On 05/15/2025 A memo was sent out to all staff stating they are not allowed to store their personal food items in the kitchen refrigerator. It was further reiterated that anything that goes in the refrigerator must be dated and marked with the date it was opened.

Moving forward:
On 05/16/2025, a small refrigerator was set up in the employee lounge for the employees to keep their lunches in. A memo sent out to the employees to sign and acknowledge the regulation regarding labeled containers. On a weekly schedule, the chef will conduct an audit regarding labeled and dated containers within the refrigerator.

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

Implemented (- 08/12/2025)

103f - Refrigerator/Freezer Temps

17. 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

At 3:35p.m. there was no thermometer in the white refrigerator in the kitchen.

Plan of Correction ***Accept ([redacted] - 06/25/2025)***

How this happened:
On 05/14/2025, while the surveyor was in the facility, the surveyor was in the kitchen checking the temps on the refrigerator and the freezers. It was discovered the thermometer was missing from the little white refrigerator in the kitchen.

Plan of correction:
On 05/14/2025, The cook at the time in the kitchen with the surveyor was assisting the with the temp checks. The cook found the thermometer in the freezer next to the refrigerator. The freezer had two thermometers in the freezer. The plan of correction was completed at that point. The thermometer was replaced back in the refrigerator immediately in front of the surveyor.

Moving forward:
On 05/14/2025 the administrator will audit the freezer and refrigerator thermometers weekly in the kitchen to ensure the thermometers are in place.

Licensee's Proposed Overall Completion Date: *06/15/2025*

Implemented ([redacted] - 08/12/2025)

105g - Lint Removal and Duct Cleaning

18. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

At 9:25a.m. there was an approximate 1/4-inch accumulation of lint in the lint trap of the dryer in the laundry room. There were no clothes in the dryer at the time.

Repeat Violation: 7/9/2024.

Plan of Correction ***Accept ([redacted] - 06/25/2025)***

How this happened:
On 05/14/2025, the housekeepers had started the morning laundry. The housekeepers failed to clean the lint trap after every use that morning. The surveyor went in to check the dryers and found the lint trap had not been emptied.

Plan of correction:
On 05/15/2025, the administrator, pulled all the housekeepers and PCA's together and explained the fire hazard it

105g - Lint Removal and Duct Cleaning (continued)

presents. The administrator drafted an audit sheet to check the lint traps daily. The administrator also drafted a check sheet and hung in the laundry room above the dryers reminding them to empty the lint traps.

Moving forward:
On 05/15/2025, the administrator will conduct a weekly audit to check the lint sheets to ensure the housekeepers are following directions, and just not happen again.

Licensee's Proposed Overall Completion Date: *06/15/2025*

Implemented (- 08/12/2025)

121a - Unobstructed Egress

19. 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

At 9:06a.m., a cardboard box and a bag of garbage was sitting in front of exit door near room 142, blocking egress from the home.

Repeat Violation: 7/9/2024.

Plan of Correction ***Accept (- 07/14/2025)***

How this happened:
On 05/14/2025 A housekeeper was emptying trash that was collected that morning and sat the bags by the back door by 142. Then went to find maintenance to help carry them out.

Plan of correction:
On 05/15/2025, the administration has adopted a new policy that the housekeeper must carry their trash out immediately or place it out back in the wheelbarrow and wheel it up to the dumpster.

Moving forward:
On 05/15/2025 When the administrator arrives in the building the administrator conducts a DAILY WALK through of the building to ensure the staff is not blocking any egress. This walk will be charted on the attached audit sheet. On 07/01, The administrator provided education to the staff regard this violation on unobstructed egress

Licensee's Proposed Overall Completion Date: *07/06/2025*

Implemented (- 08/12/2025)

125a - Combustible Storage

20. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At 9:25a.m. a dryer sheet and two wash clothes were found behind the dryer, lying on the exhaust vent, in the laundry room.

125a - Combustible Storage *(continued)*

Plan of Correction ***Accept ([redacted] - 07/14/2025)***

How this happened:
On 05/14/2025 during the annual survey it was observed that there was debris behind the dryers. There are some new employees that have failed to look and clean behind the dryer. A dryer sheet was found and two wash clothes were found lying on the vent was a dryer sheet and two wash clothes were discovered. This presents a possible situation.

Plan of correction:
On 05/14/2025, The identified violation was corrected immediately on 05/14/2025. Furthermore, the administrator drafted a log sheet and hung it in the laundry room to remind the housekeeper and PCA's to clean the lint vent and look behind the dryer for any fallen laundry. This is done on each shift.

Moving forward:
On 05/15/2025, the administrator designated a housekeeper to be the lead on checking on the condition of the dryer vents and checking behind the washers and dryers for items that may have fallen behind. DAILY CHECKS are done to ensure there are no articles such as dryer sheets and laundry behind the washer/dryers.

Licensee's Proposed Overall Completion Date: *07/06/2025*

Implemented ([redacted] - 08/12/2025)

132a - Monthly Fire Drill

21. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

A fire drill was not held during the month of October, November, or December 2024.

Repeat Violation: 7/9/2024.

Plan of Correction ***Accept ([redacted] - 06/25/2025)***

How this happened:
On 05/14/2025 the surveyor discovered there was not a fire drill recorded for the following months: October, November and December. The administrator cannot locate the record where they were recorded. It is believed they were on a separate fire drill sheet as at one point the log book was missing. The day of the survey, I was unable to locate the log. The administrator needs to be a tad bit more organized.

Plan of correction:
On 05/15/2025, Although I can't recreate the lost log, I can only move forward. The administrator hung a blank calendar was hung and specific dates are highlighted to remind the administrator to schedule the drill. A new section was designated in the DHS Manual reflecting 2025.

Moving forward:
05/15/2025 The administrator has drafted an audit sheet, to have the DHS inspection manual to be audited monthly to ensure the documents reflect correct data and are in place.

Licensee's Proposed Overall Completion Date: *06/15/2025*

132a - Monthly Fire Drill *(continued)*

Implemented ([redacted] - 08/12/2025)

132c - Fire Drill Records

22. Requirements

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

Description of Violation

The fire drill record for the drill conducted on 1/10/2025 indicates that 40 residents were in the home at the time of the drill and that 39 were evacuated. There is no documentation indicating why all residents were not evacuated for the drill. Staff indicated that Resident #3 was not evacuated due to being on hospice.

Plan of Correction ***Accept ([redacted] - 06/25/2025)***

How this happened:
The fire drill was conducted on 01/10/25. This is correct, the administrator failed to document resident # 3 was not evacuated in the last column due to being on hospice.

Plan of correction:
The administrator obtained the documentation from the Care Team Hospice and Dr [redacted] on file for resident # 3 and the reason # 3 does not evacuated.

Moving forward:
On 05/17/2025 the administrator took a fire drill schedule and highlighted every column with an explanation of what has to be filled out as a reminder of a correct fire drill record. This is hanging in the administrators office and in the fire drill log book. The assistant administrator will be following the form as a second set of eyes.

Licensee's Proposed Overall Completion Date: *06/15/2025*

Implemented ([redacted] - 08/12/2025)

132e - Fire Drill Sleeping Hours

23. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

Fire drill conducted on 1/10/25 was at 6am. Residents get up for day between 4a and 6a.
The last fire drill conducted during sleeping hours was on 8/29/24 at 10:47p.m.

Plan of Correction ***Accept ([redacted] - 06/25/2025)***

How this happened:
The administrator conducted a fire drill at 6:00 am, and thought it was within the 6 month window and considered sleeping hours. Am care is started 4:00am and then the residents are allowed to lay beck down and sleep a little more if they want. I the administrator misunderstood the regulation. I assumed the sleeping hours were between 10:00 pm and 6:00 am. When meds are passed at 7:00 am and the tech is waking up the majority if the residents are at 7:00 am. They are brought out by 7:30 am for breakfast. The administrator thought 6:00 am was within the

132e - Fire Drill Sleeping Hours (continued)

"sleeping hours" since more than half our resident are in bed by 10:00 pm and don't get up till 7:00 am.

Plan of correction:
on 05/17/2025, the Administrator conducted another drill at 11:30 pm. While this does not fall in the 6 month window, it does serve as an overnight drill.

Moving forward:
On 05/18/2025, the administrator has scheduled the overnight drills on a calendar within the office. This will serve as a reminder for the overnight drills and to help us keep the drills with in the 6 month time frame.

Licensee's Proposed Overall Completion Date: *06/15/2025*

Implemented ([redacted] - 08/12/2025)

132h - Designated Meeting Place

24. Requirements

2600.
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 #3 was not evacuated from the building or to a fire safe area during the fire drills completed 1/10/25, 2/5/25, and 3/17/25. Residents #3 & 8 were not evacuated during the fire drill conducted on 4/28/25.

Plan of Correction ***Accept ([redacted] - 07/14/2025)***

How this happened:
Resident # 3 was and is currently on hospice. The administrator as outlined above in a previous violation, did not realize that a letter was required from the attending physician. The resident was notified of the drill. Resident # 8 was not evacuated on 04/28/2025 due to being on hospice and actively dying. Resident # 8 has since passed. I'm waiting on a letter from doctor regarding hospice.

Plan of correction:
On 05/14/2025, the administrator notified Dr [redacted] and the Care Team Hospice that a letter from the doctor is needed for the file and per DHS regulation showing that the resident is actively dying. The letter has been placed in each chart and in the emergency file. Per DHS regulation, 2600.132.h, is followed to the fullest extent, and ALL residents will be evacuated from the building.

Moving forward:
The administrator will continue to monitor the progress of the hospice residents. A new fire policy regarding the evacuation regarding hospice residents has been enacted.

ALL resident will be evacuated from the building for all drills. All 13 regulations under 2600.29 and the Statement of Policy are being closely followed before allowing any resident to not evacuate during fire drills.

Licensee's Proposed Overall Completion Date: *07/06/2025*

Implemented ([redacted] - 08/12/2025)

141b1 - Annual Medical Evaluation

25. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident # 4 most recent medical evaluation was completed on [redacted] but did not include the Resident's pulse on the evaluation form.

Plan of Correction ***Accept ([redacted] - 06/25/2025)***

How this happened:
Resident # 4 had [redacted] annual medical evaluation (DME) completed on 05/02/2024 and the surveyor noted the pulse was not charted. This was an oversight on the assistant administrator on doctor day.

Plan of correction:
On 05/15/2025, Dr [redacted], resident # 4's PCP, completed a new DME on 05/15/2025. Upon closer inspection, the surveyor was looking at the DME for [redacted] The administrator has included the 05/15 DME for your review.

Moving forward:
On 05/15/2025 the administrator and the assistant administrator has conducted an audit of all DME's to ensure all the required documentation is completed. This audit will continue monthly commencing on May 15th.

Licensee's Proposed Overall Completion Date: *06/15/2025*

Implemented ([redacted] - 08/12/2025)

144c1 - Smoking Area Guidelines

26. 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:
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 home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

At 9:27 a.m., on the front porch near room 129, a paper cup full of ashes sitting on the windowsill and 4 cigarette butts that were discarded on the ground in front of the porch railing.

Plan of Correction ***Accept ([redacted] - 07/14/2025)***

How this happened:
On 05/14/2025, the survey noted the cup of ashes on the table and 4 discarded cigarette butts discarded on the ground. The overnight staff, use that exit to smoke on break, they walk off the porch to the driveway and discard their butts in a cup of water. The 4 butts discarded on the ground the administrator can't account for. I am guessing it is a visitor. There is fireproof receptacle out front the building for smokers.

Plan of correction:
On 05/20/2025 A fire proof receptacle has been placed out front on the porch. Daylight hours are from 06:31 A.M. to 07:00P.M., the designated smoking area is located out the backdoor of the building near the garage. There is a seating area for staff to take their breaks there. During evening hours from 07:00 P.M. to 06:30 A.M. the designated smoking area is located out the front west hallway door on the porch and extending to the parking lot. The

144c1 - Smoking Area Guidelines (continued)

daytime designated smoking area outback the building is dark after hours and the administrator feels for safety reason after dark the staff is not allowed to exit out the back door. Smokers will access the front parking lot away from the front of the building. The front parking lot driveway is well lit.

Moving forward:
On 05/16/2025, The administrator and assistant administrator will monitor/audit the front porch area for cigarette butts and ashes on a daily basis. This area is only used after hours on overnight for the smokers. The after hours time is from 07:00 P.M. to 06:30 A.M. A smoking receptacle has been placed within that area at the bottom of the ramp for cigarette butts.

Licensee's Proposed Overall Completion Date: *07/06/2025*

Implemented ([redacted] - 08/26/2025)

182c - Medication Administration

27. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

Description of Violation

At 8:59a.m. Staff person D was observed with a tray, which contained 6-8 medication cups with residents' names on each cup and medication in each cup. Staff person D was walking to each resident with the tray and administering medication.

Plan of Correction ***Accept ([redacted] - 06/25/2025)***

How this happened:
On 05/14/2025, Staff person D was on the floor with a tray, of med cups with residents names written on the cups and Staff D was walking to each resident with the tray and administering each medication. This is in direct violation of the proper way to pass meds.

Plan of correction:
On 05/14/2025, the administrator and assistant administrator had a meeting with Staff person D, placed Staff person D on 30 days probation, and pulled [redacted] off the cart, pending retraining. On 05/17/2025 the administrator and assistant administrator retrained Staff person D in the regulation 2600.182.c. Staff person D passed two med passes correctly following the training.

Moving forward:
On 05/17/2025 the administrator and assistant administrator will continue to monitor the med passes of Staff person D probation. Staff person D will be audited weekly to ensure staff person D is following the regulation. This will ensure the safety of all residents and the regulation is closely adhered to.

Licensee's Proposed Overall Completion Date: *06/15/2025*

Implemented ([redacted] - 08/12/2025)

187a - Medication Record

28. Requirements

2600.

187a - Medication Record *(continued)*

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

Description of Violation

Resident # 7 has an order for Nystatin 100000gm powder apply twice daily to redden skin, that is not documented on the resident's Medication Administration Record and is in the medication cart.

Repeat Violation: 7/9/2024.

Plan of Correction ***Accept (- 06/25/2025)***

How this happened:
The resident has the Nystatin 100000gm powder that the doctor ordered. It was delivered by the Pharmacy. The powder has just been delivered. The Pharmacy did not profile it in the MAR. Profiling has to be entered by the Pharmacy Staff.

Plan of correction:
On 05/14/2025, the administrator called the Pharmacy and alerted the Pharmacy of the med error. The Pharmacy Tech immediately profiled the powder to reflect the medication.

Moving forward:
On 05/15/2025, The administrator held a meeting with all med techs regarding the med carts. The med carts will now be audited weekly for med errors in the MAR. The administrator drafted an audit sheet to be filled out weekly. The administrator will also be present when the audit is conducted weekly. If any errors are located the administrator will contact the Pharmacy for immediate correction.

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

Implemented (- 09/03/2025)

225c - Additional Assessment

29. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident # 5 most recent assessment was completed on The assessment did not indicate that the resident was receiving physical therapy that began on

Repeat Violation: 3/14/2025.

Plan of Correction ***Accept (- 06/25/2025)***

How this happened:
It was discovered during the annual survey the Resident # 5's RASP was not update on the RASP that the resident was receiving the PT. This was an oversight on the administrator and assistant administrator. The assistant administrator fill the RASP out and the administrator overlooks it. WE both failed.

Plan of correction:

225c - Additional Assessment (continued)

On 05/14/2025, the administrator and assistant administrator immediately corrected the RASP to reflect the PT on 03/27/15. The Administrator and assistant administrator will conduct monthly audits on the current RASP's.

Moving forward:
On 05/16/2025 the Administrator drafted an audit sheet to reflect any changes made when a resident receives PT, OT or any other changes that occurs from a medical stand point. This includes, bed rails, speech therapy, dietary changes, physical therapy, occupational therapy, etc. This

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

Implemented (- 08/12/2025)

227d - Support Plan Medical/Dental

30. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident # 6 uses a bedside mobility device. The Resident's Support Plan dated does not reflect the specific need for the device, the intended use, the resident's ability to use the device safely, or identification of the specific device to be used.

Repeat Violation: 7/9/2024.

Plan of Correction ***Accept (- 07/14/2025)***

How did this happen:
The resident # 6 uses a bedside mobility device. The RASP did not reflect the specific need for this device, the intended use, and the residents ability to use this device or the identification of the specific device to be used.

Plan of correction:
On 06/05/2025, The Assistant Administrator corrected the # 6 Resident's RASP to reflect this need, the use, the residents ability to use and the identification of the device to be used.

Moving forward:
The Administrator and Assistant Administrator will conduct a monthly review of the RASP's commencing on May 15th, 2025.
On 06/30/2025 Further education has been provided to the staff person that complete the RASP's to include the need for the assistive device, the use of the assistive device, the residents ability to use the assistive device and identification of the device to be used.

Licensee's Proposed Overall Completion Date: *07/06/2025*

Implemented (- 08/12/2025)

253c - Records Log

31. Requirements

2600.
253.c. The home shall keep a log of resident records destroyed on or after October 24, 2005. This log must include the resident's name, record number, birth date, admission date and discharge date.

Description of Violation

Staff person A stated Resident records were destroyed within the past few months; however, a log of the required information was not retained.

Plan of Correction ***Directed (- 07/14/2025)***

How did this happen:
On 05/14/2025 the surveyor asked about records being destroyed. I answered truthfully. The former owner had all the records stored in the attic of the former office. When the office was moved, 36 years of records were placed in storage. The new owner, wanted the storage unit cleaned out of old records and debris. The maintenance department started to empty out the storage facility and discarded files. The administrator has in possession, a computer that housed a list of former residents and relevant information. However the Administrator doe not have the login information to access this on MS-DOS.

Plan of correction:
The Administrator has located files dating from 2020 and beyond. The Administrator is compiling a list with pertinent information regarding the residents. This is a tedious task.

Moving forward:
On 05/17/2025 the Administrator has begun compiling the list of residents. When completed the list will be kept in a binder located in the Administrators office and also entered into a database on the computer.

A log will be kept of all residents that have been discharged from Walden III. This log will include the residents name, record number (room number) date of birth, admission date and discharge date.

Proposed Overall Completion Date: 07/06/2025

Directed: In addition to the above plan of correction, A log will be kept of all resident records destroyed. This log will include the residents name, record number (room number) date of birth, admission date, discharge date, and the date the record was destroyed.

Directed Completion Date: *07/18/2025*

Implemented (- 08/12/2025)