pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **227 EVERGREEN ROAD OPERATIONS LLC**
LEGAL ENTITY

To operate **SANATOGA COURT**
NAME OF FACILITY OR AGENCY

Located at **227 EVERGREEN ROAD, POTTSTOWN, PA 19464**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **85** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 28**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **January 26,** **2026** until **July 26,** **2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **136141**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 26, 2026

[redacted]
227 Evergreen Road Operations, LLC
227 Evergreen Road
Pottstown, Pennsylvania 19464

RE: Sanatoga Court
License #: 136141

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection May 19, 20, and 21, 2025, September 11, 2025, and December 1 and 3, 2025 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 136140 dated June 20, 2025 to June 20, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from JANUARY 26, 2026 to JULY 26, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

[redacted]

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
81b	II	47	$5	$235	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected and full compliance with the regulation has been achieved by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
PH: 717-265-8942

[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *SANATOGA COURT* **License #:** *13614* **License Expiration:** *06/20/2025*

Address: *227 EVERGREEN ROAD, POTTSTOWN, PA 19464*

County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *227 EVERGREEN ROAD OPERATIONS LLC*

Address: *227 EVERGREEN ROAD, POTTSTOWN, PA, 19464*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *03/10/1998* **Issued By:** *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *54* **Waking Staff:** *41*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *05/21/2025*

Inspection Dates and Department Representative

05/19/2025 - On-Site: [redacted]
05/20/2025 - On-Site:
05/21/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served:** *51*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *homestead* **Capacity:** *28* **Residents Served:** *7*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *49*
Diagnosed with Mental Illness: *2*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *3*
Have Physical Disability: *3*

Inspections / Reviews

05/19/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/18/2025*

07/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/28/2025*

07/29/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/28/2025*

12/11/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

16c - Written Incident Report

1. Requirements

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

Description of Violation

On 4/12/2025, Resident 1 had a fall and suffered a facial injury. Resident 1 was sent to the hospital via ambulance. The home did not report this incident to the department.

Plan of Correction ***Accept [redacted] 07/23/2025)***

On 7/17/2025 ED reported a late report that occurred on 4/12/2025
In-service was given to staff about falls and reporting to DHW and ED
so incident reports can be filled within 24 hours if injury occurred.

ED and DHW is responsible for maintaining compliance by having meetings with Med tech daily to make sure that there are no falls with injury starting 7/17/2025

Licensee's Proposed Overall Completion Date: *08/18/2025*

Not Implemented [redacted] - 09/26/2025)

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 5/19/2025 at 10:38 am, the Medication Administration Record book was unlocked, unattended, and accessible on the medication cart.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Upon discovery, the MAR book was immediately secured and locked in accordance with facility medication handling policies. The medication cart was also locked and secured.
The staff member responsible for the cart at the time of the incident was immediately re-educated on the requirement to never leave the MAR book or cart unattended or unsecured, even briefly.
No breach of resident information or medication error was identified as a result of the incident.
An audit of medication storage practices and MAR handling procedures was conducted on 7/16/2025 by the Director of Nursing (DON) and Medication Technician Supervisor.

All medication carts and MAR books throughout the facility were checked to ensure compliance with security protocols.

No additional unsecured MAR books or unattended carts were found during the audit.
The Director of Nursing or designee will perform weekly random audits of medication carts and MAR storage

17 - Record Confidentiality (continued)

procedures for the next 90 days.

Licensee's Proposed Overall Completion Date: *08/28/2025*

Not Implemented [redacted] - 09/26/2025)

42b - Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 4/12/2025 Resident #1 suffered a fall while trying to transfer themselves after they pressed their call pendant for assistance. The resident states they waited a long period of time after they pressed their call pendant for help with transferring to their chair from wheelchair. Resident 1 does require assistance from staff according to their support plan dated 4/22/2024, for all transfers.

Resident #1 waited for about 2 hours after ringing their call pendant for assistance and then they tried to transfer themselves and fell, face first onto the floor. They pressed again and staff did not respond to their call pendant for about 2 hours. Resident 1 then eventually was able to get to their phone and called a family member, the phone number they could remember, who then called the home to advise them that the Resident had fallen and was ringing their call pendant, and no one was coming to their aid. The staff then went to the room and the resident was found on the floor next to their bed with bruising to their face and sent out for care at the emergency department at the hospital because they had hit their face and head area. Resident 1 spent a few hours at the hospital for treatment of their facial injury.

On 5/17/2025 at 11:18 am, Resident 1 pressed their pendant for assistance to the bathroom and waited 6 hours 55 minutes for someone to come help them. There are times when the resident has urinated on themselves because no one comes to assist them.

According to Resident 2's support plan, dated 1[redacted]/2024, Resident 2 has a need for toileting assistance and toileting hygiene. The staff are to provide them care while toileting and performing hygiene. Resident 2 is in a wheelchair. On 5/18/2025, Resident 2 waited 4 hours 59 minutes for assistance to be toileted. Resident 2 stated they didn't think their call bell worked because no one ever answers it. Resident 2 stated that on 5/18/2025 when they waited 4 hours 59 minutes for help to toilet they ended up having a bowel movement on themselves while waiting. Staff then had to come clean them and they felt embarrassed but they said they pressed the button as the staff have told them to do but no one answers.

According to the support plan for Resident 3, dated [redacted]/2024, Resident 3 has a need for toileting during bowel movements. Resident 3 needs assistance with proper cleaning after bowel movements. On [redacted]/2025 at 5:45 pm, Resident 3 pressed their call pendant for assistance after a bowel movement for assistance in cleaning after the bowel movement. Resident 3 was left on the toilet for 4 hours 44 minutes. They rang their call pendant, and staff did not answer the call pendant timely. Resident 3 feared they would miss their dinner meal that night, so they then pulled up their brief without the assistance to clean because staff did not come and answer the call pendant. Resident 3 then proceeded to dinner with remnants left behind on [redacted] bottom and a dirty brief. Resident 3 did develop a skin irritation in which their doctor prescribed cream to clear it for the resident.

Plan of Correction ***Accept ([redacted] - 07/28/2025)***

Staff were verbally reminded during shift huddles of the importance of prompt response to call bells and resident safety.

42b - Abuse (continued)

Any resident concerns identified were addressed individually to ensure well-being.
All direct care staff received re-training on call bell protocols and timeliness expectations. Emphasis was placed on: Responding to all call bells within 5 minutes or sooner.

Communicating with residents if a delay is expected and providing reassurance.

Logging response times when appropriate (especially for high-risk residents).
Call bell response times will be recorded on a daily basis for 30 days by shift supervisors starting 7/16/2025

Weekly Audits: The Director of Nursing (DON) or designee will review daily logs weekly for trends or continued delays. Starting 7/16/2025 for at least 30days

Licensee's Proposed Overall Completion Date: *08/28/2025*

Not Implemented [redacted] - 09/26/2025)

57d - Waking Hours

5. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 4/11/2025, a total of 64 hours of direct care was required. However, only 48.5 of the required hours were provided during waking hours.

On 4/12/2025, a total of 64 hours of direct care was required. However, only 41 of the required hours were provided during waking hours.

On 5/19/2025, a total of 64 hours of direct care was required. However, only 48.5 of the required hours were provided during waking hours.

Plan of Correction ***Accept [redacted] - 07/23/2025)***

As an immediate intervention all Department directors were pulled to the floor to help with patient safety.

Agency was brought in to help with waking hours as of 5/19/2025
DHW and ED will maintain compliance by having daily staffing meetings to go over schedules and also weekly recruitment meeting with recruiter to obtain staff (every Tuesday)

57d - Waking Hours *(continued)*

Licensee's Proposed Overall Completion Date: *08/18/2025*

Implemented [redacted] - 10/30/2025)

60a - Staff/Support Plan

6. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 4/7/2025, There were 51 residents in the home with residents who have as needed medications. There were no Medication certified staff or a nurse on duty after 11:30 pm until the next morning at 7:00 am.

On 4/11/2025, There were 51 residents in the home with residents who have as needed medications. There were no Medication certified staff or a nurse on duty after 11:30 pm until the next morning at 7:00 am.

On 4/12/2025, There were 51 residents in the home with residents who have as needed medications. There were no Medication certified staff or a nurse on duty after 11:30 pm until the next morning at 7:00 am.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

ED made sure there was a LPN or Medtech on every shift
DHW and ED will maintain compliance by holding weekly Labor meetings starting 7/16/2025 and no end date as of now. A designated manager or supervisor will verify staffing coverage for every shift via a daily checklist. Starting 7/16/2025 for 30 days

Licensee's Proposed Overall Completion Date: *08/28/2025*

Implemented [redacted] - 10/30/2025)

63a - First Aid/CPR Training

7. 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 4/11/2025, from 7:00 am to 3:00 pm, 51 residents were present in the home. During this time 1 staff person was present in the home who was certified in CPR/First Aid.

On 4/12/2025, from 7:00 am to 3:00 pm, 51 residents were present in the home. During this time 1 staff person was present in the home who was certified in CPR/First Aid.

On 5/19/2025, from 7:00 am to 3:00 pm, 51 residents were present in the home. During this time 1 staff person

63a - First Aid/CPR Training (continued)

was present in the home who was certified in CPR/First Aid.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

ED Made sure staff members in non-compliance have been scheduled for CPR certification and recertification courses immediately.

Priority was given to direct care staff who have the highest risk of needing CPR.

All new hires will be required to be CPR-certified prior to being assigned direct care responsibilities.

Current staff will undergo CPR certification or recertification within the next 30 days class scheduled in Aug 2025

A CPR certification tracking system has been implemented to ensure no staff member is allowed to work unless their certification is current as of 7/16/2025 with no end date.

A list of all CPR-certified employees will be reviewed and updated on a monthly basis by the facility manager to prevent gaps in certification coverage.

Supervisors will maintain a CPR certification roster that is reviewed regularly for compliance.

Licensee's Proposed Overall Completion Date: *08/28/2025*

Not Implemented [redacted] - 09/26/2025)

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Personal care service needs of the resident.
6. Safe management techniques.

Description of Violation

Direct care staff person A did not receive training in meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, personal care service needs of the resident, safe management techniques during training year 2024.

Plan of Correction ***Accept [redacted] - 07/29/2025)***

Direct care staff person A was immediately removed from direct care duties upon discovery of the training deficiency.
On [5/19/2025],
Staff A completed a comprehensive training that included instruction on all required areas:
Preadmission screening form Resident assessment tools Medical evaluations Support plans Personal care service needs
Safe management techniques

65f - Training Topics (continued)

Documentation of training completion is maintained in Staff A's personnel file.

An audit of all direct care staff training records was conducted by the Administrator on 05/20/2025.

All staff files were reviewed to ensure compliance with required annual training. Any deficiencies identified were corrected by scheduling and completing necessary training by 8/20/2025.

Licensee's Proposed Overall Completion Date: *08/28/2025*

Not Implemented [redacted] - 09/26/2025)

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).
5. Falls and accident prevention.

Description of Violation

Staff person A did not receive training in the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year 2024.

Plan of Correction ***Accept [redacted] - 07/29/2025)***

On 5/20/2025] Staff person A completed training in the following required areas:
Older Adult Protective Services Act (OAPSA), including mandatory reporting requirements and protections for vulnerable adults.
Falls and accident prevention, including risk factors, prevention strategies, and response protocols.
Training was conducted by ED and DHW documentation of completion has been placed in Staff A's personnel file.
An internal audit of all employee training records was conducted by the Administrator on 07/16/2025 to determine if any other staff were missing required training in these areas.
Any identified deficiencies were immediately addressed and corrected by scheduling and completing the appropriate training no later than 8/30/2025

Licensee's Proposed Overall Completion Date: *08/28/2025*

Not Implemented [redacted] - 09/26/2025)

81b - Resident Personal Equipment

10. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

81b - Resident Personal Equipment *(continued)*

Description of Violation

On 5/19/2025, The enabler belonging to Resident 2 was not secured to the bed frame.
Repeat Violation: 11/25/24 et al

Plan of Correction ***Accept [redacted] - 07/29/2025)***

Upon discovery on 5/19/2025, the enabler was immediately removed by the ED properly secured to the bed frame per manufacturer guidelines and facility policy.

Resident #2 was assessed by nursing staff for any signs of injury or distress. No injuries were observed or reported.
The staff involved were immediately re-educated on the proper installation, use, and safety protocols regarding enablers and assistive devices.
A full inspection of all residents utilizing enablers or assistive equipment was conducted by the nursing and maintenance departments on 7/16/2025
No other improperly installed or unsafe enablers were found.
Documentation of this inspection is on file and was reviewed by the Administrator and Director of Nursing.
A standardized checklist for the safe installation of enablers will now be completed and signed off by both nursing and maintenance staff upon any new enabler setup starting 7/16/2025

Staff training on safe use, positioning, and securing of enablers was held on 7/16/2025, and will now be included in new hire orientation and annual mandatory training.

Maintenance staff will verify all bed-related equipment for safety during routine monthly safety rounds and after any bed/equipment changes.

Licensee's Proposed Overall Completion Date: *08/28/2025*

Not Implemented ([redacted] - 09/26/2025)

82c - Locking Poisonous Materials

11. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 5/19/2025, There was an unlocked, unsecured Spa Room that had multiple items, hand sanitizer with a manufacture's label indicating "to contact poison control", was unlocked, unattended, and accessible to residents. Not all the residents of the home, including all residents located in the Secure Care Dementia Unit have been assessed

82c - Locking Poisonous Materials (continued)

capable of recognizing and using poisons safely.

On 5/19/2025, There was an unlocked, unsecured Spa Room that had multiple items, Degree deodorant with a manufacture's label indicating "to contact poison control", was unlocked, unattended, and accessible to residents. Not all the residents of the home, including all residents located in the Secure Care Dementia Unit have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 07/29/2025)***

On 5/19/2025, the Spa Room was immediately secured and locked by the ED while all hazardous materials (nail polish, hand sanitizer, deodorant) were removed and stored in a locked, staff-only area in accordance with facility policy and safety guidelines.
A thorough inspection of the Spa Room was conducted to ensure no additional unsafe items remained accessible.A safety check was conducted throughout the facility to ensure all unsecured hazardous materials were properly locked and inaccessible to residents.
On 7/16/2025 a complete audit of all storage areas, activity rooms, and resident-accessible spaces was completed by the Administrator and Director of Nursing to identify and secure all potentially hazardous items. Weekly audits will take place from 7/16/2025 completion date scheduled for 8/28/2025

Licensee's Proposed Overall Completion Date: *08/28/2025*

Not Implemented [redacted] - 09/26/2025)

85a - Sanitary Conditions

12. Requirements

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

Description of Violation

On 5/19/2025, there was a strong odor that smelled similar to cat urine in room [redacted].

Plan of Correction ***Accept [redacted] - 07/29/2025)***

On 5/19/2025, Housekeeping was immediately dispatched to Room [redacted] to perform deep cleaning of the entire room, including flooring, bedding, furniture, and any personal items contributing to the odor.
The room was temporarily ventilated, and a specialized odor neutralizer was applied following all safety and environmental protocols.
No resident was occupying Room [redacted] other rooms near room [redacted] were assessed for any hygiene, incontinence, or environmental concerns that may have contributed to the odor, and an individualized care plan adjustment was made as necessary.
The Director of Nursing will review resident hygiene care plans for accuracy and consistency with current needs Housekeeping DHW and ED will conduct weekly inspections of hallways and room for strong odors starting 7/16/2025

Licensee's Proposed Overall Completion Date: *08/28/2025*

Not Implemented [redacted] - 09/26/2025)

86b - Bathroom

14. 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 bathrooms in resident rooms and public restrooms, do not have an operable window or ventilation fan. The fan is inoperable and there is no window in the bathroom.

Plan of Correction ***Directed [redacted] 07/29/2025)***

On 5/20/2025 the Maintenance Department inspected all affected bathrooms and confirmed that the ventilation fans were inoperable and that no operable windows were present. Temporary corrective measures were implemented, including:

Use of portable air circulators and dehumidifiers in common restroom areas where feasible.

Increased frequency of housekeeping rounds to maintain cleanliness and odor control as of 7/16/2025

A full audit of all bathrooms in resident rooms and public areas was conducted on 7/16/2025 will cont weekly

86b - Bathroom (continued)

until compliance is met.

Proposed Overall Completion Date: 08/28/2025

Directed

Within 10 calendar days of the accepted POC: The administrator or designee will contact a company to repair or replace all inoperable exhaust fans. Invoices will be kept for Department review. Documentation of completed work will be sent to the Department via SansWrite.[redacted] 7/29/25

Directed Completion Date: *08/28/2025*

Not Implemented[redacted] - 09/26/2025)

88a - Surfaces

15. 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 5/19/2025, The home had a leaking roof HVAC unit. The unit was causing leaking onto the floors with yellow wet floor signs and buckets to collect the water that was leaking.

On 5/19/2025, Room[redacted] has a window that leaks whenever it rains and comes in the window and leaks down into the PTAC window unit. The walls are stained from the leak at the top and side of the window.

On 5/19/2025, the floor tiles in the emergency exit stairwell located near the Secured Care Dementia Unit were warped and lifting off the floor.

Plan of Correction ***Accept[redacted] - 07/29/2025)***

The leaking HVAC unit underwent inspection by maintenance personnel on May 19, 2025. Temporary containment measures, including buckets and wet floor signage, were implemented to ensure resident and staff safety pending the completion of repairs.

Room[redacted] was inspected, and the resident's condition was monitored to preclude any safety or health risks. Supplemental towels and absorbent materials were utilized as a provisional measure during periods of rainfall. Maintenance will assess the window in Room 106 and undertake necessary repairs or engage a window contractor.

The emergency stairwell floor was cordoned off with caution tape to restrict access and mitigate trip hazards while arrangements for repair were being finalized. The floor in the emergency exit hallway has since been repaired.

A licensed HVAC contractor was engaged on May 20, 2025, and a service appointment was scheduled for May 29th 2025 to inspect and repair the roof unit and thereby eliminate the leak.
Regonial Maintance director is conducting weekly inspections and repairs of HVAC starting 7/3/2025 till 8/28/2025

Licensee's Proposed Overall Completion Date: *08/28/2025*

88a - Surfaces *(continued)*

Not Implemented [redacted] - 09/26/2025)

91 - Telephone Numbers

16. 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 telephone in room [redacted].

Plan of Correction ***Accept [redacted] - 07/29/2025)***

ED notified maintenance the following emergency contact numbers will be posted next to the telephone in room [redacted]
Nearest hospital Fire department and other required number
All staff will be informed of this update to ensure they know where to find emergency contacts should a situation arise. A memo will be distributed on 7/16/2025
Room inspections will be conducted by all staff to ensure that emergency numbers are displayed prominently and are legible starting 7/16/2025
The ED will implement a quarterly review of all emergency contact postings in every room to ensure compliance.
A checklist will be developed and reviewed during routine room inspections by the ED and DHW starting 7/16/2025

Licensee's Proposed Overall Completion Date: *08/28/2025*

Implemented [redacted] - 09/26/2025)

182b - Prescription Medication

17. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

Description of Violation

On 5/1/2025 at 12:00 am, staff person A administered medications to residents to include the following: Aripiprazole 10 mg tablet. Staff person A is not a certified medication technician.

Plan of Correction ***Accept [redacted] - 07/29/2025)***

ED immediately removed Staff Person A from any medication administration duties until proper certification is obtained or a new staff member is assigned.
Medications that were administered by Staff Person A on 5/1/2025 will be verified for accuracy by a certified medication technician or supervising nurse. A follow-up check of the residents' health status will be done by a

182b - Prescription Medication (continued)

licensed nurse to ensure no adverse reactions have occurred.Staff Person A will be educated on the importance of only administering medications if they hold the required certification and the potential risks involved when regulations are not followed. Staff A has received the correct training.
Staff Person A will receive a formal training session on medication administration and the legal and regulatory requirements for non-certified staff. This session was completed

A medication administration policy will be reinforced with all staff to ensure that only qualified personnel handle and administer medications.
A monthly audit of medication administration records will be conducted to ensure compliance with policies and regulations. Starting 7/16/2025
Supervisory staff will conduct random checks of medication administration throughout the facility to ensure only certified personnel are administering medications for the next two months.

Licensee's Proposed Overall Completion Date: *09/28/2025*

Not Implemented [redacted] - 09/26/2025)

183c - Refrigerated Meds Locked

18. Requirements

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

On 5/19/2025 at 10:27 am, The Medication Administration Cart, holding multiple residents' medications, was unlocked and unsecured.

On 5/19/2025 at 10:49 am, The Medication room was unlocked and unsecured, along with three medication carts, holding multiple residents' medications, were all unlocked and unsecured.

Plan of Correction ***Accept ([redacted] - 07/29/2025)***

By EOD on 5/19/2025, the Medication Administration Cart and all medication storage areas will be locked and secured.
All residents' medications will be properly secured immediately following this incident.
A licensed nurse or certified medication technician will verify that all medication carts and the Medication Room are properly secured at the start and end of each shift.
An immediate inventory check will be conducted to ensure no medications are missing or tampered with.
All staff will be required to undergo a mandatory re-education session on the facility's medication storage and security policies. This training will include:
The proper procedure for securing the Medication Administration Cart and Medication Room.
The importance of ensuring medications are kept in a locked and secured location at all times to maintain safety and compliance.
.
The re-education session will be completed by 8/1/2025 and all new staff will receive the same training as part of their on-boarding.

183c - Refrigerated Meds Locked (continued)

Medication room and cart security will be monitored regularly by supervisory staff to ensure compliance. Random audits will be conducted by ED and DHW at least 3 times per week until 8/30/2025
Any staff found to be non-compliant with medication security protocols will be subject to corrective action, which may include retraining, written warnings, or disciplinary measures as appropriate.

Licensee's Proposed Overall Completion Date: *08/28/2025*

Not Implemented [redacted] - 09/26/2025)

224a - Preadmission Screen Form

20. Requirements

2600.

224a - Preadmission Screen Form *(continued)*

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 4 was admitted to the home on [redacted]/2024; however, the resident's preadmission screening form was not completed.

Plan of Correction ***Accept [redacted] - 07/29/2025)***

The preadmission screening form for Resident 4 will be completed and placed in the resident's file. By DHW no later than 6/19/2025

A registered nurse or designated staff member will review the form to ensure it is fully completed and that all necessary information is documented accurately.

A supervisor or case manager will verify that the form is completed correctly and complies with all state and facility regulations.

A review of the admission process will be conducted to ensure that all required documentation, including the preadmission screening form, is completed before or at the time of admission.
A checklist will be created and implemented for all new admissions to ensure that the preadmission screening form is completed as part of the intake process. This checklist will be reviewed by supervisory staff to confirm compliance as of 7/16/2025

The checklist will include the following items:Completion of the preadmission screening form. Verification of any additional required documents (e.g., medical history, consent forms, etc.). Confirmation that the resident's care plan is started or reviewed.
All staff involved in the admission process will receive mandatory training on the importance of completing the preadmission screening form, along with other admission documentation.
Supervisory staff will conduct random audits of resident admissions to verify that all required documents, including the preadmission screening form, are completed and filed correctly.
An audit of admissions will be conducted on a monthly basis, with findings reviewed during the facility's staff meetings to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *08/28/2025*

Not Implemented [redacted] - 09/26/2025)

225c - Additional Assessment

21. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 1's most recent assessment was completed on [redacted]/2024.

225c - Additional Assessment (continued)

Resident 3's most recent assessment was completed on [redacted]2024.

Resident 4's most recent assessment was completed on [redacted]/2024.

Plan of Correction ***Accept[redacted] - 07/29/2025)***

By7/30/2025 the overdue assessments for Resident 3 and Resident 4 will be completed and documented by the DHW.

The assessment for Resident 1 will be reviewed to ensure it meets the regulatory requirements and is updated if necessary.

A licensed nurse or designated staff member will complete a thorough review of each resident's care plan and update any changes or needs identified during the assessments.

Supervisory staff will verify that the assessments have been completed and are in compliance with all applicable regulations going forward 7/16/2025

A review of the facility's assessment process will be conducted to ensure that assessments are scheduled in a timely manner and that all required assessments are completed within the regulatory time frame.

A standardized tracking system will be put in place to monitor assessment dates for each resident. This system will generate automated reminders for the nursing staff at least 25 days before the required assessment date.

The facility will implement monthly audits to ensure that all residents have completed assessments within the required time frame starting 7/16/2025

The auditing process will involve reviewing the resident's assessment records to confirm that the assessments are completed and filed correctly. Supervisors will follow up on any discrepancies or overdue assessments.

Any missed or overdue assessments will be immediately addressed, and the responsible staff will be notified for corrective action.

Licensee's Proposed Overall Completion Date: *08/28/2025*

Implemented[redacted] - 09/26/2025)

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

Facility Information

Name: *SANATOGA COURT* **License #**: *13614* **License Expiration**: *06/20/2026*

Address: *227 EVERGREEN ROAD, POTTSTOWN, PA 19464*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *227 EVERGREEN ROAD OPERATIONS LLC*

Address: *227 EVERGREEN ROAD, POTTSTOWN, PA, 19464*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/10/1998* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *09/11/2025*

Inspection Dates and Department Representative

09/11/2025 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *47*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SCDU* **Capacity**: *28* **Residents Served**: *7*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *7* **Have Physical Disability**: *0*

Inspections / Reviews

09/11/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/06/2025*

Inspections / Reviews *(continued)*

10/24/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/08/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/28/2025*

10/30/2025 - POC Submission

Submitted [redacted] **Date Submitted:** *12/08/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/07/2025*

12/11/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/08/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 9/11/2025, at 9:17 am, Licensing Representative, an agent of the Department, requested access to resident records, CPR Information for all staff, and call bell logs for all residents for 30 days. Staff person A refused to provide access until 9/11/2025 at 2:45 pm. The call bell logs were not provided until the following day 9/12/2025.

Plan of Correction ***Accept [redacted] - 10/24/2025)***

The ED will provide access to all requested documents immediately upon request.
The ED will ensure that all documents are accurate and up to date.
The ED will have a binder specifically dedicated to maintaining these documents, this will allow for immediate access upon request.
The ED will obtain all requested documents by 11/11/25.

Licensee's Proposed Overall Completion Date: *11/11/2025*

Implemented [redacted] - 12/10/2025)

16c - Written Incident Report

2. Requirements

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

Description of Violation

On 8/11/2025, resident 1 had a fall in their bathroom that caused a Pubic ramus fracture to their left side. The home did not report this incident to the Department until 8/14/2025.

Plan of Correction ***Accept [redacted] - 10/24/2025)***

The ED will within 24 hours report any known or suspected injury to the DHS via telephone or email.
The ED / DHW will re-educate all DCS on reporting incidents and abuse.
This education will continue annually and as needed.
Education will begin 09/12/25.

Licensee's Proposed Overall Completion Date: *11/07/2025*

Not Implemented [redacted] - 12/10/2025)

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 9/1/2025, from 11:00 pm to 7:00 am, 47 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid, obstructed airway techniques and CPR.

63a - First Aid/CPR Training (continued)

On 9/6/2025, from 11:00 pm to 7:00 am, 47 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid.

Plan of Correction ***Accept [redacted] - 10/24/2025)***

The ED will ensure that all DCS are CPR and first aid certified and that the certifications are maintained as required by the DHS.
The ED will maintain a binder with these certifications which will allow immediate access.
The ED will require staff to provide a copy of certifications upon renewal.
Documents will be available 10/ /25.

Licensee's Proposed Overall Completion Date: *11/03/2025*

Not Implemented [redacted] - 12/10/2025)

65b - Rights/Abuse 40 Hours

5. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person C completed [redacted] 40th scheduled work hour on 7/16/2025. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

65b - Rights/Abuse 40 Hours (continued)

Plan of Correction ***Accept ([redacted] - 10/30/2025)***

The Director of HR with help of ED and DON has implemented a new Orientiation check lists and all new staff are unable to be on the floor unless the following are completed 1. Resident rights. 2. Emergency medical plan. 3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102). 4. Reporting of re-portable incidents and conditions. These courses are in our welcoming program that is required before hands on orientation is allowed.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 12/10/2025)

65d - Initial Direct Care Training

6. Requirements

2600.

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

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
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.
   - x. Staff person supervision, if applicable.
   - 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 B, hired on [redacted] 2025, began providing unsupervised ADL services on 7/8/2025. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

65d - Initial Direct Care Training (continued)

Direct care staff person C, hired on [redacted] 2025, began providing unsupervised ADL services on 7/8/2025. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept [redacted] - 10/24/2025)***

The Director of HR will ensure that no DCS works independently until all training is completed.
The Director of HR will verify successful completion and passing of competency test via the DHS website.
Beginning 09/12/25

Licensee's Proposed Overall Completion Date: *11/03/2025*

Not Implemented [redacted] - 12/10/2025)

65e - 12 Hours Annual Training

7. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

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

Plan of Correction ***Accept [redacted] - 10/24/2025)***

The DHW will ensure that each staff member receives at least 12 hours of annual training related to their job duties.
The DHW will ensure that staff members receive this training through video and or in person.
The DHW will monitor and verify completion annually.
Beginning 09/12/25

Licensee's Proposed Overall Completion Date: *11/03/2025*

Implemented [redacted] - 12/10/2025)

81b - Resident Personal Equipment

8. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 9/11/2025, the bedside mobility device for resident 2 was not installed per manufacturer's instructions as it was not secured to the bed frame.

On 9/11/2025, the bedside mobility device for resident 3 was not installed per manufacturer's instructions as it was not secured to the bed frame.

81b - Resident Personal Equipment (continued)

Repeat Violation: 11/25/24 et al

Plan of Correction ***Accept (- 10/24/2025)***

The maintenance director will inspect and properly install the bed mobility device to the bed frame per the manufacturer's instructions.
The DCS will check the bed mobility device daily to ensure that it remains properly attached to the bed frame.
The DCS will immediately report if the device loosens or becomes displaced.

Licensee's Proposed Overall Completion Date: *10/08/2025*

Not Implemented - 12/10/2025)

82c - Locking Poisonous Materials

9. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Scrub Free oven cleaner, with a manufacturer's label indicating "contact poison control", was unlocked, unattended, and accessible to residents in the memory care kitchen. Not all the residents of the home, including memory care residents, have been assessed capable of recognizing and using poisons safely.

Dove Deodorant, with a manufacturer's label indicating "contact poison control", was unlocked, unattended, and accessible to residents in the memory care room . Not all the residents of the home, including memory care residents, have been assessed capable of recognizing and using poisons safely.

Sparklefresh Mouthwash, with a manufacturer's label indicating "contact poison control", was unlocked, unattended, and accessible to residents in the memory care room Not all the residents of the home, including memory care residents, have been assessed capable of recognizing and using poisons safely.

Colgate Toothpaste, with a manufacturer's label indicating "contact poison control", was unlocked, unattended, and accessible to residents in the memory care room Not all the residents of the home, including memory care residents, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 10/24/2025)***

The scrub free oven cleaner was immediately removed from the kitchen area.
The Dove soap, sparkle fresh mouthwash and Colgate toothpaste were immediately removed from the resident's room and stored in a secure closet.
DCS will check the residents' room daily to ensure that no other hazardous items are present.

Licensee's Proposed Overall Completion Date: *10/07/2025*

Not Implemented - 12/10/2025)

85a - Sanitary Conditions

10. Requirements

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

Description of Violation

On 9/11/2025, at 11:05 am, memory care room [redacted] had a strong odor of urine and feces smeared on the toilet seat.

Plan of Correction ***Accept [redacted]/24/2025)***

The DCS will monitor and assist the residents with incontinence care as needed.
The DCS will check the resident's room, remove and launder any soiled clothing daily.
The DHW will request the resident's bathroom be cleaned daily

Licensee's Proposed Overall Completion Date: *10/08/2025*

Not Implemented [redacted] - 12/10/2025)

88a - Surfaces

11. 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 9/11/2025, there were water stained ceiling tiles in bedroom [redacted] and in the bathroom of room [redacted]

Plan of Correction ***Accept [redacted] - 10/24/2025)***

The director of maintenance will replace the damaged ceiling tiles, check for leaks, and make any needed repairs.
The director of maintenance will do daily walks to check for potential hazards and make repairs as needed.
The razor in room [redacted] was immediately removed and placed in a secure closet.
The DCS will check the resident's rooms daily for potential hazards

Licensee's Proposed Overall Completion Date: *10/07/2025*

Not Implemented [redacted] - 12/10/2025)

101j7 - Lighting/Operable Lamp

12. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 5 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept [redacted] - 10/24/2025)***

The DHW instructed the resident to place a lamp on [redacted] bedside table.
The DHW will check monthly to see that the lamp remains in place at the bedside

Licensee's Proposed Overall Completion Date: *10/07/2025*

101j7 - Lighting/Operable Lamp *(continued)*

Implemented [redacted] - 12/10/2025)

182b - Prescription Medication

13. 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

On 9/10/2025 and 9/11/2025, at 8:00 am, staff person E administered medications to residents to include the following: Amlodipine 10 mg, and Acetaminophen 500 mg. Staff person E is not 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.

Plan of Correction ***Accept [redacted] - 10/30/2025)***

Immediate Correction:

Upon identification, Staff Person E was immediately removed from medication administration duties until proper re certification was completed. Staff Person E successfully renewed Med Tech certification through an approved Train-the-Trainer instructor on September 13, 2025, and was reinstated to full medication administration duties upon verification of the certification.

2. Preventive Measures:

The Administrator or Designee will verify all staff Med Tech certifications prior to scheduling medication

182b - Prescription Medication (continued)

administration duties.

A Certification Tracking Log has been implemented to monitor expiration dates of all Med Tech certifications.

Staff will receive a reminder 30 days prior to certification expiration to allow time for re certification.

3. Monitoring and Quality Assurance:

The Administrator will review the Certification Tracking Log monthly to ensure all Med Techs remain current.

Any staff found to have an expired certification will be immediately removed from med cart responsibilities until re certified.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] - 12/10/2025)

190b - Insulin Injections

14. 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 9/10/2025, at 8:00 am, staff person E, who has not successfully completed the Department-approved medications administration course, administered insulin to resident 2.

Plan of Correction ***Accept [redacted] - 10/30/2025)***

Immediate Correction:
Upon identification, Staff Person E was immediately removed from medication administration duties until proper re certification was completed. Staff Person E successfully renewed Med Tech certification through an approved Train-the-Trainer instructor on September 13, 2025, and was reinstated to full medication administration duties upon verification of the certification.

2. Preventive Measures:

The Administrator or Designee will verify all staff Med Tech certifications prior to scheduling medication administration duties.

A Certification Tracking Log has been implemented to monitor expiration dates of all Med Tech certifications.

190b - Insulin Injections (continued)

Staff will receive a reminder 30 days prior to certification expiration to allow time for re certification.

3. Monitoring and Quality Assurance:

The Administrator will review the Certification Tracking Log monthly to ensure all Med Techs remain current.

Any staff found to have an expired certification will be immediately removed from med cart responsibilities until re certified.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] 12/10/2025)

224a - Preadmission Screen Form

15. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 6 was admitted to the home on [redacted]/2025; however, the resident's preadmission screening form was not completed.

Resident 7 was admitted to the home on [redacted]/2025; however, the resident's preadmission screening form was not completed.

Resident 8 was admitted to the home on [redacted]/2025; however, the resident's preadmission screening form was not completed.

Plan of Correction ***Directed [redacted] - 10/30/2025)***

Preadmission screening forms for Residents 6, 7, and 8 have since been completed and placed in their resident records.

The Administrator reviewed each file to ensure all other required admission documentation was present and accurate.

Proposed Overall Completion Date: 10/30/2025

224a - Preadmission Screen Form (continued)

Directed

By 11/7/25: The administrator or designated staff person will create and implement a system to ensure all residents being admitted to the home have a preadmission screening completed in its entirety, to include an indication the home can meet the resident's needs. All staff persons involved with resident admissions will be educated regarding the new system. Documentation of the education will be kept. The administrator or designated staff person will review all new resident preadmission screening forms prior to admission for accuracy and completion including the staff person completing the form has determined the home can meet the needs of the resident. [redacted] *10/30/25*

Directed Completion Date: *11/07/2025*

Not Implemented [redacted] ***- 12/10/2025)***

231c - Preadmission Screening

16. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 9 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] */2025. However, resident 9's written cognitive preadmission screening was not completed.*

Plan of Correction ***Accept*** [redacted] ***- 10/30/2025)***

All current residents in the Secure Dementia Care Unit were reviewed to ensure their preadmission cognitive screenings were on file and compliant.

2. Preventive Measures:

Effective immediately, no resident will be admitted to the Secure Dementia Care Unit without a completed and documented cognitive preadmission screening form signed by a physician or geriatric assessment team within 72 hours prior to admission.

The Admissions Coordinator and Administrator will jointly verify the presence of this completed screening before any admission paperwork is finalized

All staff involved in admissions have been re-educated on the regulatory requirements for cognitive preadmission screenings and documentation.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Not Implemented [redacted] ***- 12/10/2025)***

236 - Staff Training

17. Requirements

2600.

236 - Staff Training *(continued)*

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person E, who works in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2024 training year.

Repeat Violation: 11/25/24 et al

Plan of Correction ***Accept (- 10/30/2025)***

All DCS will complete Dementia care training as required.
The ED will ensure that all DCS complete their dementia care training.
by monitoring their compliance annually
Effective immediately, all direct care staff assigned to the SDCU will be required to complete six (6) hours of dementia-specific training annually.

The Staff Development Coordinator (or Administrator) will ensure that the dementia training is separate from the general 12-hour annual training requirement.

A Training Tracker Log will be maintained to monitor and document completion dates for both the 12-hour annual training and the additional 6-hour dementia training.

Staff will be scheduled for dementia training at least 60 days prior to their annual due date to prevent future lapses.

A Training Calendar has been implemented and posted in the staff office to track all required annual education sessions.

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented 12/10/2025)