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

September 25, 2025

[redacted]
RAPPS SENIOR CARE LLC
[redacted]
ATTN BILL SNOW
[redacted]

RE: WOODBRIDGE PLACE
1191 RAPPS DAM ROAD
PHOENIXVILLE, PA, 19460
LICENSE/COC#: 14359

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/02/2025 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: *WOODBRIDGE PLACE* **License #**: *14359* **License Expiration**: *12/21/2025*

Address: *1191 RAPPS DAM ROAD, PHOENIXVILLE, PA 19460*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *RAPPS SENIOR CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/01/1996* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *116* **Waking Staff**: *87*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *06/02/2025*

Inspection Dates and Department Representative

06/02/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served**: *86*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Lilac* **Capacity**: *20* **Residents Served**: *19*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *85*

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

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

06/02/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/04/2025*

07/08/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/18/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/10/2025*

Inspections / Reviews *(continued)*

07/14/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/18/2025*

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

09/25/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/18/2025*

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

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On or about [redacted] a family member of Resident [redacted] reported to Staff Person A that Resident [redacted] was upset and reported to them that an unnamed staff person made the following statements to Resident [redacted]

- *"nobody cares for you"*
- *"nobody wants to work with you"*
- *"all of the staff hate you"*
- *"nobody wants to change you"*

On [redacted] at 11:00 AM, a family member of Resident [redacted] contacted Staff Person A to report unauthorized use of Resident 1's debit card at multiple locations, totaling in the amount of approximately [redacted] in fraudulent purchases.

On [redacted] at approximately 8:10 AM, Staff Person B found Resident [redacted] purse in the trash can of the ladies' bathroom in the basement of the home.

However, none of these incidents were reported to the local area agency on aging.

Repeat violation: [redacted]

Plan of Correction ***Directed ([redacted] - 07/11/2025)***

2600.15a-
Previous Administrator failed to report 3 incidents to AAA involving resident 1 and was terminated on 5/27/25.
b. Resident 1 was clinically re-assessed by the DOW on 6/27/2025—no new physical or psychosocial harm noted; counseling offered.
c. Resident 1's debit-card losses) reimbursed by [redacted] bank; staff member under investigation was terminated on 5/13/2025. Staff member did not work with any residents after receipt of report on 5/12/2025.
d. Resident 1's valuables were secured by resident's responsible party.
All associates to complete suspected abuse reporting by 7.18.2025.
All directors to complete training by 7.18.2025 regarding incidents that require reporting to local area agency on aging in accordance with the Older Adult Protective Services Act.
New hire onboarding includes suspected abuse reporting.
Administrator to complete weekly audit of incident reports to verify compliance on reporting timelines for 12 weeks.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented ([redacted] - 09/25/2025)

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On or about [redacted] a family member of Resident [redacted] reported to Staff Person A that Resident [redacted] was upset and reported to them that an unnamed staff person made the following statements to Resident [redacted]

- *"nobody cares for you"*
- *"nobody wants to work with you"*
- *"all of the staff hate you"*
- *"nobody wants to change you"* .

During an internal investigation completed by Staff Person A, it was determined that Staff Person C was the individual involved in this allegation of abuse, however, the home did not develop and implement a plan of supervision or suspend Staff Person C.

Repeat violation: [redacted]

Plan of Correction ***Directed ([redacted] - 07/11/2025)***

2600.15b
Staff member C was terminated on 5/13/2025. The Administrator that failed to conduct the internal investigation was terminated on 5/27/25. Once the concerns were identified by DHS during a complaint survey appropriate actions were taken by the corporate team.
The Administrator is to complete weekly audit of any complaint reports to verify compliance with requirement to develop and implement a plan of supervision or suspend staff persons involved with an allegation of abuse for 12 weeks.
Staff training on "Incident and Complaint Reporting" began on 6/17/25 and will be completed by all staff by 7/18/25.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented ([redacted] - 09/25/2025)

16c - Written Incident Report

3. 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 or about [redacted] a family member of Resident [redacted] reported to Staff Person A that Resident [redacted] was upset and reported to them that an unnamed staff person made the following statements to Resident [redacted]

16c Written Incident Report (continued)

- *"nobody cares for you"*
- *"nobody wants to work with you"*
- *"all of the staff hate you"*
- *"nobody wants to change you"*

On [redacted] at approximately 8:10 AM, Staff Person B found Resident [redacted] purse in the trash can of the ladies bathroom in the basement of the home.

The home did not report these incidents to the department.

Repeat violation [redacted]

Plan of Correction ***Accept ([redacted] - 07/11/2025)***

2600.16c
Previous Administrator who failed to report the reportable events was terminated on 5/27/25. Moving forward the Administrator is to report all reportable incidents when necessary. Staff training on Incident and Complaint Reporting began on 6/17/25 and will be completed on 7/18/25.

All associates to complete suspected abuse reporting by 7.18.2025.
All directors to complete training by 7.18.2025 regarding incidents that require reporting to local area agency on aging in accordance with the Older Adult Protective Services Act and reporting to DHS within 24 hours.

Licensee's Proposed Overall Completion Date: *07/18/2025*

Implemented ([redacted] - 09/25/2025)

16e - Resident Notice

4. Requirements

2600.
16.e. If the home's final report validates the occurrence of the [redacted]eged incident or condition, the affected resident and other residents who could potentially be harmed or [redacted] designated person shall also be informed immediately following the conclusion of the investigation

Description of Violation

On [redacted] at 11:00 AM, a family member of Resident 1 contacted Staff Person A to report unauthorized use of Resident [redacted] debit card at multiple locations, totaling in the amount of approximately [redacted] in fraudulent purchases. Police identified Staff Person C as the individual who made the fraudulent purchases, and on [redacted], Staff Person C was terminated and arrested on site, however, the home did not inform other residents of the home who could potentially be harmed, or their designated persons, as of [redacted]

Plan of Correction ***Directed ([redacted] - 07/11/2025)***

2600.16e
Previous Administrator failed to inform residents and families of the theft of a credit card. Families and residents

16e Resident Notice (continued)

were informed by email on 6/11/25 that the theft occurred in the community. A copy of this email will be submitted with supporting documentation. All directors to complete training by 7.18.2025 regarding notifying of the conclusion of investigation if validated, the affected resident and all other potentially affected residents.
Administrator to complete weekly audit of incident reports to verify compliance with requirement to notify the affected and all potentially affected residents of the conclusion of investigation if validated, for 12 weeks.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented (- 09/25/2025)

42b - Abuse

5. 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 , Staff Person C was bragging to Staff Persons D and E about going "out to spend a bunch of money after work" and that was "going to get a couple things at The following day, on , Staff Person C came into work and told Staff person D "I went and spent a whole bunch of money yesterday" and showed Staff Person D a bracelet Staff Person C had bought and told Staff Person D about some shoes bought as well.

On the morning of , Staff Persons D and E were in Resident s room providing assistance to the resident. While in the room with the resident, Resident received a telephone call from a family member. After the resident hung up the phone told Staff Persons D and E that family member said "someone spent a couple hundred dollars on my card and the police might be coming" because they "think it might be someone from here".

On at 11:00 AM, a family member of Resident 1 contacted Staff Person A to report unauthorized use of Resident debit card at multiple locations, including Staff Person A then shared this information with Staff Person F. A little while later, Staff Person F was walking through the hall and heard a few people talking about a staff person who was "bragging about a spending spree" they had been on. Staff Person F asked a few more questions and then informed Staff Person A about what had heard. Staff Person A then spoke to Staff Persons D and E, who told Staff Person A about their conversations and interactions with Staff Person C over the weekend, as well as providing written statements.

The total amount of the combined purchases was approximately . The family member provided transaction and store location information for the fraudulent purchases, which allowed the police to quickly obtain video from those locations. Police were then able to verify Staff Person C as the individual who used the card to make the fraudulent purchases. Staff Person C was not scheduled to work on On , when Staff Person C arrived for shift, the police were on location. Staff person C was terminated and arrested at that time.

On , at approximately 8:10 AM, Staff Person B was emptying the trash in the ladies' room in the basement of the home. Staff Person B thought the trash bag was unusually heavy and looked into the bag and found a "beige,

42b Abuse (continued)

brown purse". Staff Person B opened the purse to see if there was a name in it, found the purse belonged to Resident [redacted].

Plan of Correction ***Directed ([redacted] - 07/11/2025)***

2600. 42b
The previous Administrator was notified by family member on 5/12/25 of fraudulent use of resident's debit card. Police were immediately notified by Administrator and staff member C was taken into custody before the start of their shift on 5.13.25.
b. Resident [redacted] was clinically re assessed by the DOW on 6/27/2025 no new physical or psychosocial harm noted; counseling offered.
c. Resident [redacted] debit card losses) reimbursed by [redacted] bank; staff member under investigation was terminated on 5.13.2025. Staff member did not work with any residents after receipt of report on 5/12/25.
d. Resident [redacted] valuables were secured by resident's responsible party.
All associates to complete suspected abuse reporting by 7.18.2025.
All associates to complete Residents rights training by 7.18.2025.
All associates to complete Respectful communication training by 7.18.2025
New hire onboarding includes suspected abuse reporting and resident rights training.
DOW to observe two resident staff interactions three days weekly for twelve weeks. The observations will be documented on weekly audit form and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented ([redacted] - 09/25/2025)

42c - Treatment of Residents

6. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On or about [redacted] a family member of Resident [redacted] reported to Staff Person A that Resident [redacted] was upset and reported that an unnamed staff person made the following statements to Resident [redacted]:

- *nobody cares for you"*
- *nobody wants to work with you"*
- *all of the staff hate you"*
- *nobody wants to change you"*

During an internal investigation completed by Staff Person A it was determined that Staff Person C was the individual involved.

42c Treatment of Residents *(continued)*

Plan of Correction ***Directed (- 07/11/2025)***

2600.42.c

Staff member C was terminated on 5.13.25. Staff person C did not work with any residents after receipt of report on 5.12.2025. Police were notified by Administrator and staff member C was taken into custody before the start of their shift on 5.13.25.

Resident 1 was clinically re assessed by the DOW on 6/27/2025 no new physical or psychosocial harm noted; counseling offered.

Resident 1's debit card losses) reimbursed by bank; staff member under investigation was terminated on 5.13.2025. Staff member did not work with any residents after receipt of report on 5/12/2025.

Resident 1's valuables were secured by resident's responsible party.

All associates to complete suspected abuse reporting by 7.18.2025.

All associates to complete Respectful communication training by 7.18.2025

All associates to complete Resident Rights training by 7.18.2025.

New hire onboarding includes suspected abuse reporting and resident rights.

DOW to observe two resident staff interactions three days weekly for twelve weeks. The observations will be documented on weekly audit form and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented (- 09/25/2025)

65a - FS Orientation 1st Day

7. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person G, whose first day of work was , did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking

65a FS Orientation 1st Day (continued)

areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, or, telephone use and notification of emergency services.

Staff person H, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, or, telephone use and notification of emergency services.

Plan of Correction ***Directed ([redacted] - 07/11/2025)***

2600. 65a FS Orientation
Staff member G and H are agency associates. Staff member G completed the missing Day 1 fire safety orientation and 40 hour modules on 7/5/2025. Staff member H completed the missing Day 1 fire safety orientation and 40 hour modules on 6/24/2025.
New Hire training for community implemented with staff agency on 6/12/2025. Associates from agency must complete training prior to working with community.
Training and development coordinator to verify completion of new hire training prior to approving agency associates for shifts.
Business Office Director to review schedules weekly and verify that any agency staff used has completed new hire training. Aduit to be begin week of 7.7.2025 and continue for 12 weeks and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented ([redacted] - 09/25/2025)

65b - Rights/Abuse 40 Hours

8. 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 G completed [redacted] 40th scheduled work hour on [redacted]

65b Rights/Abuse 40 Hours (continued)

. 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) or reporting of reportable incidents and conditions.

Plan of Correction ***Directed (- 07/11/2025)***

2600.65b Rights/Abuse 40hours
Staff member G is an agency associate. Staff member G completed the missing Day 1 fire safety orientation and 40 hour modules on 7/5/2025.
New Hire training for community implemented with staff agency on 6/12/2025. Associates from agency must complete training prior to working with community.
Training and development coordinator to verify completed of new hire training prior to approving agency associates for shifts.
Business Office Director to review schedules weekly and verify that any agency staff used has completed new hire training. Aduit to begin week of 7.7.2025 and continue for 12 weeks and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented (- 09/25/2025)

65d - Initial Direct Care Training

9. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person I, hired on began providing unsupervised ADL services on . Staff Person I's CNA license expired on . Staff Person I continued to provide unsupervised ADL services after however, did not complete and pass the Department approved direct care training course and pass the competency test until

Plan of Correction ***Directed (- 07/11/2025)***

2600. 65d Initial Direct Care Training

65d Initial Direct Care Training (continued)

Staff person I completed department approved direct care training course and passed competency test on 6.12.2025.
Audit of all associated files to be completed by Business Office Director by 7.18.2025.
Audit of all new associate files to be completed by Business Office Director weekly for 12 weeks and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented (- 09/25/2025)

65e - 12 Hours Annual Training

10. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person J received 5 hours of annual training in training year 2024.

Plan of Correction ***Directed (- 07/11/2025)***

2600. 65e 12 hours annual training
Staff Member J completed annual training for missing 2024 topics by 6/10/2025.
Audit of all associated files to be completed by Business Office Director by 7.18.2025.
Schedule of training to be implemented by Business Office Director by 7.01.2025 to ensure all associates have completed 12 hours of annual training related to their job duties prior to end of year 2025.
Annual training calendar implemented and posted on 7.01.2025.
Business Office Director to audit training monthly beginning July 2025 through December 2025 to verify monthly training completion compliance and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Proposed Overall Completion Date: 12/31/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented (- 09/25/2025)

65f - Training Topics

11. Requirements

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person I did not receive training in medication self-administration during training year 2024.

Direct care staff person J did not receive training in medication self-administration , instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, safe management techniques during training year 2024.

Plan of Correction ***Directed ([redacted] - 07/11/2025)***

2600. 65f- Training topics
Staff member I completed missing 2024 training topics 6/6/2025.
Staff member J completed missing 2024 topics on 6/10/2025.
Audit of all associated files to be completed by Business Office Director by 7.18.2025.
Schedule of training to be implemented by Business Office Director by 7.1.2025 to ensure all associates have completed 12 hours of annual training related to their job duties prior to end of year 2025.
Annual training calendar implemented and posted on 7.1.2025.
Business Office Director to audit training monthly beginning month of July 2025 through December 2025 to verify monthly training completion compliance and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Proposed Overall Completion Date: 12/31/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented ([redacted] - 09/25/2025)

65g - Annual Training Content

12. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

65g - Annual Training Content *(continued)*

2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person J did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, or new population groups that are being served at the home that were not previously served, if applicable during training year 2024.

Plan of Correction ***Accept ([redacted] - 07/11/2025)***

Prior to or during the first workday, all direct care staff persons shall have an orientation per regulation 2600. 65. covering the following subjects,

1. Evacuation procedures

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.

4. Smoking safety procedures, the homes smoking policy and location of smoking areas if applicable.

5. The location and use of fire extinguishers.

6. Smoke detectors and fire alarms.

7. Telephone use and notification of emergency services.

Business Office Manager to audit all employee files to ensure compliance with regulation 2600.65g. This audit will be completed by 7/18/25.

Staff person J did complete the required training, which was in [redacted] employee file and dated 4/20/2023. This form will be available to the Department.

Licensee's Proposed Overall Completion Date: *07/18/2025*

Implemented ([redacted] - 09/25/2025)

183b - Meds and Syringes Locked

13. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On [redacted], [redacted] and [redacted] were unlocked, unattended, and accessible in room [redacted] Resident [redacted] resides in this room and is not capable of self-administering medications.

183b Meds and Syringes Locked *(continued)*

Plan of Correction ***Accept (- 07/08/2025)***

2600.183b Meds and Syringes Locked
Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.
On 6/22 Zinc Oxide paste and A & D ointment were unlocked, unattended and accessible in apartment 221. This ointment and paste were removed immediately from the apartment by the staff nurse and locked on the medication cart when identified by the surveyor.
Audit was conducted on June 30th, 2025, by [redacted] LPN of all residents' apartments to assure that any medication is stored properly, if permitted to be stored in the apartment. (Documentation of this audit and results to be provided to the Dept. upon request).
A weekly audit of 5 random resident apartments will continue to be conducted by [redacted] LPN or a staff nurse, starting the week of July 7, 2025, until September 23, 2025. This audit tool to be used will check for unattended, unlocked medications/syringes, and will document all findings including any medications that were found out and the remedial action taken as well as which apartments were audited. (Documentation of this audit to be provided to the Department upon request).
Medication Techs will be in serviced by [redacted] LPN, Certified Medication Trainer, on this regulation, and the training will be completed by July 9, 2025, (documentation of this in service to be provided to the Dept. upon request).

Licensee's Proposed Overall Completion Date: *07/08/2025*

Implemented (- 09/25/2025)

185a - Implement Storage Procedures

14. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The following glucometer readings for Resident [redacted] were not documented correctly in the resident's medication administration record (MAR):

- *On [redacted] at 7:56 AM a glucometer reading of [redacted] was documented in the MAR as [redacted].*
- *On [redacted] at 12:21 PM a glucometer reading of [redacted] was documented in the MAR as [redacted].*
- *On [redacted] at 8:28 PM a glucometer reading of [redacted] was not documented in the MAR.*
- *On [redacted] at 8:48 AM a glucometer reading of [redacted] was not documented in the MAR.*

Repeat violation: [redacted]

Plan of Correction ***Accept (- 07/08/2025)***

2600.185a Implement Storage Procedures
The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.
Glucometer readings for resident 1 were not documented correctly on two different occasions in the resident's

185a Implement Storage Procedures (continued)

medication administration record.
In service was conducted by [redacted] LPN, Medication Trainer, for the medication technicians, DOW and staff LPN starting on June 30, 2025, and will be completed for all medication technicians by July 9, 2025. The in service will educate the med. tech. staff members on regulation 2600 185a highlighting proper documentation from the glucometer reading of a blood sugar to the transcribing of that number into the MAR. (This In service will be available to the Department upon request).
Glucometer audits will be put into place on June 30, 2025. The audit form will be used to check 5 various residents glucometer readings and compare that number to the number documented in the MAR, 1x weekly. This audit will be conducted by [redacted] LPN, the DOW or [redacted] designee.
The in service and the glucometer audit forms will be available for the Department to review per request. This weekly audit will be completed on September 1, 2025.

Licensee's Proposed Overall Completion Date: *07/08/2025*

Implemented ([redacted] - 09/25/2025)

15. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident [redacted] is prescribed [redacted] oral tablet as needed. On [redacted] this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 07/08/2025)***

2600.185a
The home should develop and implement procedures for safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.
Resident [redacted] is prescribed [redacted] oral tablet as needed. On 6/2/25 this medication was not available in the home.
On 6/2/25, the pharmacy was contacted by the staff nurse and the Hyoscyamine sulfate was ordered for resident 1 and the medication arrived to the community the following morning.
House Pharmacy conducted cart audits on June 24 June 25, 2025 to ensure all medications are available for all residents.
A mandatory In Service will be completed by [redacted] LPN, a Certified Med. Trainer, for all Med. techs., including the Director of Wellness and staff LPN, starting on 6/30/25 and will be completed by 7/3/25. The In Service will review regulation 2600 185 along with reeducating the proper process of ordering medications prior to the medication running out. The In Service will be available for the department upon request.
Weekly med cart audits, x3 months will be put in place starting July 7, 2025, through October 7, 2025. The DOW or [redacted] designee will conduct the weekly cart audit to ensure that all medications are available to be administered by the doctor's order.
The in service and audit forms will be documented and available to view when requested.

Licensee's Proposed Overall Completion Date: *07/08/2025*

185a - Implement Storage Procedures *(continued)*

Implemented (- 09/25/2025)

16. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The home's medication policy states "each time a resident receives assistance with self-administration/administration of a narcotic, this is documented and the amount of medication on hand is updated on the Narcotic Count Sheet".

- *the removal of one tablet, dated at 7:39 AM, was recorded on the controlled substance record for Resident on*
- *the removal of one tablet, dated at 8:42 PM, was recorded on the controlled substance record for Resident twice, on and*
- *On , the controlled substance record for Resident prescribed 1 syringe by mouth every 4 hours as needed indicates a remaining count of 29 syringes, however, there were 2 empty syringes and 1 syringe with only (5mg) left in the syringe, making the actual correct count of syringes 26.*

The home's medication policy states "when a narcotic is received in the community, it is counted by two staff members and added to the narcotic sheet with the current medication count reflected in the amount on hand".

- *The controlled substance record for Resident 's prescribed tablet initially indicated a count of 120 on . It appears that on or about this number was crossed out and changed to a count of 114, and the count amounts adjusted, and then declined from the altered count entered. There is no indication that 2 staff members counted this medication and accurately documented the initial count on the controlled substance record when received on*

The homes medication policy states "at the end of each shift, the staff member responsible for medications who is completing shift, and the staff member responsible for medications who is starting shift, count narcotic medications and confirm that the amount on hand matches what is listed on the Narcotic Count Sheet for each medication. Both staff members will sign a Narcotic Reconciliation Sheet to confirm the accurate count of narcotics on hand.

- *On and staff responsible for medications on the 3rd floor medication cart did not complete the required shift change narcotic medication counts.*
- *On , staff responsible for medications on the 1st floor medication cart did not complete the required shift change narcotic medication counts.*

Plan of Correction ***Accept (- 07/08/2025)***

2600.185a -The homes medication policy states "each time a resident receives assistance with self-administration/administration of a narcotic, this is documented and the amount of medication on hand is updated on the Narcotic Count Sheet".
On 6/2/25 the controlled substance record for resident 4's prescribed 1 syringe by mouth q 4 hrs. PRN indicates a remaining count of 29 syringes, however there were 2 empty syringes and 1 syringe with only .05 ml of in the syringe, making the actual correct count of syringes to

185a - Implement Storage Procedures (continued)

be 26.
On 6/9/25 two nurses discarded the 2 empty syringes together and wasted the syringe of morphine with .25 ml of medication in it. Both nurses signed off on the proper narcotic form.
A mandatory In-Service will be completed by [redacted] LPN, a Certified Med. Trainer, for all Med. techs., including the Director of Wellness and staff LPN, starting on 6/30/25 and will be completed by 7/3/25.
The In-Service will review regulation 2600 185 along with re-training the importance of following procedures of counting the narcotics and checking to be sure that the syringes are not compromised along with checking that the tablet foil is not broken. Nurses and Med. Tech's are to report to the DOW and/or the Administrator if a narcotic is compromised. The In-Service will be available for the department upon request.
Weekly med cart audits, x3 months will be put in place starting July 7, 2025, through October 7, 2025. The DOW or [redacted] designee will conduct the weekly cart audit to ensure that all medications are available to be administered by the doctor's order. The cart audit will also capture that all narcotic counts are correct, and that no syringes are leaking or empty. The Narcotic Count Sheet will be monitored to ensure that the counts are completed and correct on each narcotic.
The in-service and audits will be documented and available for view when requested by the Department.
The controlled substance record for Resident [redacted]s prescribed [redacted] initially indicated a count of 120 on 5/19/25. It appears that on or about 5/22/25 this number was crossed out and changed to a count of 114, and the count amounts adjusted, and then declined from the altered count entered. There is no indication that 2 staff members counted this medication and accurately documented the initial count on this controlled substance record when received from the family on 5/19/25.
On 6/2/25 the staff nurses counted the [redacted]l together to verify the count was correct. On 7/7/25, pharmacy delivered 2 bubble cards of [redacted], quantity of 30 tablets each for resident [redacted] Bottle that was originally delivered upon move in for resident #3 were contacted to come pick up the 14 tablets of Tramadol in a bottle.
A mandatory In-Service will be completed by [redacted] LPN, a Certified Med. Trainer, for all Med. techs., including the Director of Wellness and staff LPN, starting on 6/30/25 and will be completed by 7/3/25.
The In-Service will review regulation 2600 185 along with re-training the importance of following procedures of counting the narcotics when receiving by two nurses and both signing off on the count sheet and checking to be sure that the syringes are not compromised along with checking that the tablet foil is intact. Nurses and Med. Tech's are to report to the DOW and/or the Administrator if a narcotic is compromised.
Weekly med cart audits, x 3 months will start July 7, 2025, through October 7, 2025. The DOW or [redacted] designee will conduct the weekly cart audit to ensure that all medications are available to be administered by the doctor's order. The in-service and cart audit will also capture that all narcotic counts are correct, and that no syringes are leaking or empty. The Narcotic Count Sheet will be monitored to ensure that the counts are completed and correct on each narcotic. This in-service audit will also check all controlled substance records to be sure that two staff members have counted the medication, and signatures are noted on the sheet.
This in-service training and ongoing cart audits will be documented and available for view when requested by the Department.
On 5/9 and 5/18 staff responsible for medications on the 3rd floor cart did not complete the required shift change narcotic medication counts.
On 6/1 staff responsible for medications on the 1st floor cart did not complete the required shift change narcotic medication counts.
A mandatory In-Service will be completed by [redacted] LPN, a Certified Med. Trainer, for all Med. techs., including the Director of Wellness and staff LPN, starting on 6/30/25 and will be completed by 7/3/25.
The In-Service will review regulation 2600 185 along with re-training the importance of following procedures of counting the narcotics and checking to be sure that the syringes are not compromised along with checking that the

185a Implement Storage Procedures (continued)

tablet foil is not broken. Nurses and Med. Tech's are to report to the DOW and/or the Administrator if a narcotic is compromised. This In Service will capture the importance of the med. tech. staff and nurses to ensure they count the narcotics together and document the counts completed on the Narcotic Reconciliation Sheet.
Weekly med cart audits, x3 months will be put in place starting July 7, 2025, through October 7, 2025. The DOW or [redacted] designee will conduct the weekly cart audit to ensure that all medications are available to be administered by the doctor's order. The cart audit will also capture that all narcotic counts are correct, and that no syringes are leaking or empty. The Narcotic Count Sheet will be monitored to ensure that the counts are completed and correct on each narcotic. The Narcotic Reconciliation Sheets will be monitored by the DOW or designee on the weekly cart audits to ensure that the staff members are properly counting the narcotics to confirm that the amount on hand matches what is listed on the Narcotic Count Sheet and signing off on the Narcotic Reconciliation Sheet.
If it is observed and noted during the weekly cart audit that a nurse or med. tech. is not completing the end of shift narcotic count before or after their shift with the other staff member, then disciplinary action of a suspension for 2 days will occur. If a staff member returns after suspension and it is observed that the staff member is still not participating in a shift narcotic count, then that staff member will be terminated.
This in service and audits will be documented and available for view when requested by the Department.

Licensee's Proposed Overall Completion Date: *07/08/2025*

Implemented ([redacted] - 09/25/2025)

186c - Change in Medications

17. Requirements

2600.
186.c. Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by nurses in accordance with regulations of the Department of State. The resident's medication record shall be updated as soon as the home receives written notice of the change.

Description of Violation

On [redacted] the home's controlled substance record for Resident [redacted] indicates the resident is prescribed Tramadol 50 mg, one tablet by mouth every 6 hours as needed, however, on [redacted] the prescription for this medication was changed to [redacted] tablet take 1 tablet by mouth twice daily. A change of direction was not indicated on the controlled substance record.

Plan of Correction ***Accept ([redacted] - 07/08/2025)***

2600.186c Change in Medications
Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by nurses in accordance with regulations

186c Change in Medications (continued)

of the Department of State. The resident's medication record shall be updated as soon as the home receives written notice of the change.
On 6/2/25, the homes controlled substance record for Resident [redacted] indicates the resident is prescribed Tramadol 50 mg, one tablet by mouth every 6 hours as needed, however on 5/18/25 the prescription for this medication was changed to [redacted] mg tablet, take 1 tab by mouth twice daily. A change of direction was not indicated on the controlled substance record.
On 6/2/25, the staff LPN verified the order for the Tramadol and placed a change of order sticker on the packaging of the medication to ensure compliance.
A mandatory In Service will be completed by [redacted] LPN, a Certified Med. Trainer, for all Med. techs., including the Director of Wellness and staff LPN, starting on 6/30/25 and will be completed by 7/3/25. The In Service will re educate staff on regulation 2600.186c. If a nurse or med. tech observes a medication order in the EMAR compared to the bottle or card of medication are not matching, they are to immediately notify the DOW or the Administrator so that the medication order can be verified to ensure accuracy and compliance.
Weekly med cart audits, x3 months will be put in place starting July 7, 2025, through October 7, 2025. The DOW or [redacted] designee will conduct a weekly cart audit to ensure that all medications are available to be administered per the doctor's order. If there were any changes in medication orders the DOW or [redacted] designee during the cart audit will ensure that the medications are updated as soon as the home receives written notice of the change.
The cart audit will also ensure that all narcotic counts are correct, and that no syringes are leaking or empty. The Narcotic Count Sheet will be monitored during the audit to ensure that the counts are completed and correct on each narcotic. The Narcotic Reconciliation Sheets will be monitored by the DOW or [redacted] designee during the weekly cart audit to ensure that the staff members are properly counting the narcotics to confirm that the amount on hand matches what is listed on the Narcotic Count Sheet and signing off on the Narcotic Reconciliation Sheet.

Licensee's Proposed Overall Completion Date: *07/08/2025*

Implemented ([redacted] - 09/25/2025)

224a - Preadmission Screen Form

18. 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 [redacted]'s preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Directed ([redacted] - 07/11/2025)***

2600.18. 224a Pre admission screen form
Resident 5's pre admission screening from was reviewed and updated on 6/3/2025 to include the required determination that the resident's needs can be met by the services provided at the home.
An audit of all active resident preadmission screening forms completed since January 1, 2025, to be completed by DOW or designee by 7.18.2025. Any errors or omissions identified to be corrected and noted as corrected.
All directors to complete training by 7.18.2025 regarding department required forms and process for new admissions, specifically regarding the pre admission form, the PA RASP, and DME.
Administrator will audit all new move ins weekly to verify that department required documents have been

224a - Preadmission Screen Form (continued)

obtained and completed. Audit to continue for 12 weeks and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented (- 09/25/2025)

225a - Assessment 15 Days

19. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident who was admitted to the home on

Plan of Correction ***Directed (- 07/11/2025)***

2600.225a- Assessment
Resident 's assessment was completed on 6/3/25 by LPN staff nurse, signed and verified in chart.
An audit of all active resident assessments who have moved in since January 1, 2025, to be completed by DOW or designee by 7.18.2025. Any errors or omissions identified to be corrected and noted as corrected.
All directors to complete training by 7.18.2025 regarding department required forms and process for new admissions, specifically regarding the pre-admission form, the PA RASP, and DME.
Administrator will audit all new move- ins weekly to verify that department required documents have been obtained and completed. Audit to continue for 12 weeks and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented (- 09/25/2025)

227g -Support Plan Signatures

20. Requirements

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

Description of Violation

Resident Staff Person K participated in the development of Resident s support plan on . However, Staff Person K did not sign the support plan.

227g -Support Plan Signatures (continued)

Resident Staff Person K participated in the development of Resident [redacted]s support plan on [redacted] However, Staff Person K did not sign the support plan.

Plan of Correction ***Directed ([redacted] - 07/11/2025)***

2600.227g- Support Plan Signatures
Staff person K signed the support plan of residents 2 and 5 on 6/3/2025.
An audit of all active resident assessments who have moved in since January 1, 2025, to be completed by DOW or designee by 7.18.2025. Any errors or omissions identified to be corrected and noted as corrected.
All directors to complete training by 7.18.2025 regarding department required forms and process for new admissions, specifically regarding the pre-admission form, the PA RASP, and DME.
Administrator will audit all new move- ins weekly to verify that department required documents have been obtained and completed. Audit to continue for 12 weeks and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented ([redacted] - 09/25/2025)

231c - Preadmission Screening

21. 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 [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, Resident [redacted] written cognitive preadmission screening was not completed as of [redacted]

Plan of Correction ***Directed ([redacted] - 07/11/2025)***

2600.231c- Preadmission Screening
Resident transferred from Personal care to memory care neighborhood on 5.29.2025.
An audit of all active residents admitted to the memory care since January 1, 2025, to be completed by DOW or designee by 7.7.2025. Any errors or omissions identified to be corrected and noted as corrected.
Administrator to In-Service DOW, staff LPN, Sales and Marketing Director and Business Office Manager on all required forms, timelines and the process for new admissions, specifically regarding the pre-admission form, the PA RASP, and DME. In-Service will be completed by 7/14/25.
Administrator will audit all new move- ins weekly to verify that department required documents have been obtained and completed timely. Ongoing audit of new move ins to be completed monthly by DOW or designee through 10/01/25.

Proposed Overall Completion Date: 10/01/2025

231c - Preadmission Screening (continued)

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented (- 09/25/2025)

234a - Admission Support Plan

22. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident was admitted to the Secure Dementia Care Unit (SDCU) on . However, the resident's initial support plan was not completed.

Plan of Correction ***Directed (- 07/11/2025)***

2600.234.a - Admission Support Plan
Resident transferred from Personal care to memory care neighborhood on 5.29.2025. RASP completed and signed on DATE for resident and placed in chart.
An audit of all active residents admitted to the memory care since January 1, 2025, to be completed by DOW or designee by 7.18.2025. Any errors or omissions identified to be corrected and noted as corrected.
All directors to complete training by 7.18.2025 regarding department required forms and process for new admissions, specifically regarding the pre-admission form, the PA RASP, and DME.
Administrator will audit all new move- ins weekly to verify that department required documents have been obtained and completed. Audit to continue for 12 weeks and findings to be reported to and reviewed during monthly Quality Assurance meeting and committee to make recommendations for continued monitoring.

Proposed Overall Completion Date: 10/01/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented (- 09/25/2025)

236 - Staff Training

23. Requirements

2600.
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 J, who works in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2024 training year.

Direct care staff person L, who works in the Secure Dementia Care Unit (SDCU) had only 4 hours of training in dementia care during the 2024 training year.

236 - Staff Training *(continued)*

Plan of Correction ***Directed (- 07/11/2025)***

2600.236 - Staff Training
Staff member J and L to complete 6 hours of dementia training by 7.18.2025.
Audit of all associated files to be completed by Business Office Director by 7.18.2025
Schedule of training to be implemented by Business Office Director by 7.18.2025 to ensure all associates who work in Secure Dementia Care Unit have completed 6 hours of dementia care training in addition to 12 hours of annual training prior to end of year 2025.

Business Office Director to audit future training monthly beginning in July 2025 through December 2025 to verify monthly training completion.

Proposed Overall Completion Date: 12/31/2025

Directed Completion Date 7/18/25

Directed Completion Date: *07/18/2025*

Implemented (- 09/25/2025)