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

September 17, 2025

CHRISTIAN LIFE SERVICES INC

RE: CHRISTIAN LIFE SERVICES
3408 -10 NORTH 19TH STREET
PHILADELPHIA, PA, 19140
LICENSE/COC#: 13279

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/05/2025, 06/12/2025, 06/18/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CHRISTIAN LIFE SERVICES* **License #**: *13279* **License Expiration**: *07/25/2025*

Address: *3408 10 NORTH 19TH STREET, PHILADELPHIA, PA 19140*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *CHRISTIAN LIFE SERVICES INC*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *02/03/2015* **Issued By**: *City of Philadelphia, L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *26* **Waking Staff**: *20*

Inspection Information

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

Reason: *Complaint, Monitoring* **Exit Conference Date**: *06/05/2025*

Inspection Dates and Department Representative

06/05/2025 - On-Site: [redacted]
06/12/2025 - On-Site: [redacted]
06/18/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *44* **Residents Served**: *26*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *16* **Are 60 Years of Age or Older**: *10*
Diagnosed with Mental Illness: *26* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

06/05/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/20/2025*

Inspections / Reviews *(continued)*

07/21/2025 POC Submission

Submitted By: [redacted]
Date Submitted: *08/18/2025*
Reviewer: [redacted]
Follow Up Type: *POC Submission*
Follow Up Date: *07/26/2025*

07/30/2025 POC Submission

Submitted By: [redacted]
Date Submitted: *08/18/2025*
Reviewer: [redacted]
Follow Up Type: *Document Submission*
Follow Up Date: *08/15/2025*

09/17/2025 Document Submission

Submitted By: [redacted]
Date Submitted: *08/18/2025*
Reviewer: [redacted]
Follow Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On [redacted] the home's copy of 55 Pa.Code Chapter 2600 were being kept in the office, which is locked when Administrative staff are not present, and not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 07/21/2025)***

Immediate action, current license was placed in 3 other conspicuous and public places during inspection on 06/05/25
Immediate corrective action: Retrain all staff with this is violation to by 07/25/25.
Administrator/office manager will monitor regulatory updates and communicate changes.
Preventive actions: administrator will communicate and monitor with office manager weekly and monitor all areas to ensure all conspicuous and public areas have all posted current license and summaries issued by the department.

Licensee's Proposed Overall Completion Date: *07/30/2025*

Implemented [redacted] - 09/17/2025)

5a1 - DHS Access

2. 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 [redacted] at 9:55 AM, agents of the Department, requested access to a list of residents living in the home, a list of staff, and resident records. Staff person A did not have access to the information and could not provide or locate the resident/staff lists. Staff person B, the Administrator took several resident records, including those requested by agents of the Department, off-site.

On [redacted], at 9:16 AM, agents of the Department, requested access to the storage area on the right side of the basement. Staff person A reported they have never been back there, and they do not have keys that allows access.

Plan of Correction ***Accept ([redacted] - 07/21/2025)***

The administrator met with DHS representatives to resolve the access issue on 06/12/25.
All requested records were provided. All staff were retrained on the importance of regulatory access compliance on 7/14/25. Written policy was created and given to all staff on DHS Access to the records and all storage areas.
The administrator/designee will conduct quarterly audits to ensure staff compliance.
All corrective actions were completed on 7/16/25

Licensee's Proposed Overall Completion Date: *07/21/2025*

5a1 - DHS Access *(continued)*

Implemented ████ - 09/17/2025)

15a - Resident Abuse Report

3. 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 ████, at 9:40 AM, Resident █ was sitting outside of the home. Resident █ was talking to themself and walking around. Resident █ walked up to ████ and accused Resident 1 of stealing from Resident █. ████ then swung out and hit Resident █ on the left side of the face, near the eye. Staff person A was immediately aware that this incident occurred on ████ at 9:40 AM. However, this was not reported to the local area agency on aging.

Plan of Correction ***Accept ████ - 07/21/2025)***

1. Corrective Action Taken

- *The suspected abuse was reported to the appropriate protective services agency immediately upon discovery.*
- *The involved staff person was retrained.*
- *The resident and their designated representative were notified of the report.*

2. Systemic Change Implemented

- *A written policy titled "Suspected Abuse Reporting Protocol" was revised on 7/15/25 to include:*
- *Immediate reporting procedures to protective services.*
- *Staff restriction guidelines during investigations.*
- *Notification procedures for residents and their representatives.*
- *The policy was posted in the office and other conspicuous public places in common areas of the home*

3. Staff Training

• All staff received mandatory training on abuse recognition and reporting protocols by the administrator/nurse on 7/15/25
• Training included documentation procedures.
• New hires will receive this training during onboarding.

4. Monitoring and Quality Assurance

• The administrator will conduct monthly audits of incident reports to ensure timely reporting.

Licensee's Proposed Overall Completion Date: *07/21/2025*

Implemented ████ - 09/17/2025)

16c - Written Incident Report

4. 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 , at 9:40 AM, Resident was sitting outside of the home. Resident was talking to themself and walking around. Resident walked up to Resident and accused Resident of stealing from Resident Resident then swung out and hit Resident on the left side of the face, near the eye. Staff person A was immediately aware that this incident occurred on at 9:40 AM. However, the home did not submit an incident report to the Department.

Plan of Correction ***Directed (- 07/30/2025)***

To avoid delays in reporting all incidents will be reported to RA-pwarsoutheast@pa.gov as per regulations going forward all incidents will be reported within 24 hours as per regulation chapter 2600.
All staff will be retrained on 7/27/25

Proposed Overall Completion Date: 08/13/2025

Directed POC:

Immediately: *The administrator or designee shall complete incident reports for the incidents involving residents' #1 and #2 and submit the reports to the BHSL Southeast Regional Office.*

Immediately: *The administrator or designee shall review all reportable incidents and conditions at least weekly to ensure all reportable incidents and conditions are reported to the Department in accordance with regulation 2600.16c.*

Within 5 days of receipt of the plan of correction: *All staff persons will be educated on the home's policy and procedures for reportable incidents and conditions including the reporting requirements. Documentation of education shall be kept in accordance with 2600.65i.*

Directed Completion Date: *08/13/2025*

Implemented - 09/17/2025)

17 - Record Confidentiality

5. 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 , at 7:00 am, resident records were unlocked, unattended, and accessible on the table located in front of the printer in the front office.

17 Record Confidentiality *(continued)*

Plan of Correction ***Accept - 07/21/2025)***

The records were secured once the issue was identified on 06/12/25.
The Administrator conducted a same day review with the responsible staff person and reinforced the importance of confidentiality and secure storage of resident records.
Monitoring and Quality Assurance
• The administrator/designee will conduct weekly audits to ensure all files are in a locked and secured area at all times.

Licensee's Proposed Overall Completion Date: *07/14/2025*

Implemented - 09/17/2025)

42s - Privacy

6. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On at 7:00 am, Staff person A administered medications to residents in the medication room while being monitored by a camera. The camera footage was being live streamed in the front office on a large television screen.

Plan of Correction ***Directed (- 07/30/2025)***

The live video stream was immediately disabled once the issue was identified on 06/12/2025.
All Camera was removed from all privacy areas as of 06/12/2025.
The Administrator /designee will review the cameras ongoing effective 06/13/25 to be sure that the resident's privacy is meet at all times.

Proposed Overall Completion Date: 07/25/2025

Directed steps of POC:

Immediately: *Video recording is, permitted in areas completely inaccessible to residents. Video recording of the homes entrances and exits, as well as interior corridors leading to the entrances and exits is also permitted, provided the residents are informed these areas are subject to video recording and signs are posted in the areas indicating they are being recorded. All other areas of the home are prohibited from being recorded.*

Immediately: *The administrator shall check weekly to ensure there is no video recording in the home except areas specified above.*

Directed Completion Date: *08/01/2025*

Implemented - 09/17/2025)

62 - Contact List

7. Requirements

62 - Contact List *(continued)*

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

The Administrator has not maintained a current list of the names, address, and telephone numbers of the homes staff persons including substitute personnel and volunteers.

Plan of Correction ***Accept (- 07/30/2025)***

The Administrator compiled and updated the staff list to include the full names, home addresses, phone numbers, and roles. The list was verified for accuracy with each employee/volunteer. This was completed by 07/14/2025. On 7/15/25 a tracking form has been implemented to monitor all required documents, files and charts the administrator/designee will conduct a review along with updating the files every time there is a new hire the charts and files will be checked regularly to make sure that the home is in compliance.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented - 09/17/2025)

65f - Training Topics

8. 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 A did not receive training in infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, or care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2024.

Direct care staff person C did not receive training in care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2024.

Plan of Correction ***Accept (- 07/30/2025)***

All direct care staff were notified of the training deficiency and will be completed by 08/13/2025.
Schedule mandatory training sessions covering required topics (resident rights, mental illness, fire safety, infection control, dementia).
- Utilize DHS-approved providers Temple University's Direct Care Staff Training Program.
Effective 06/15/25 Administrator / Designee will audit training records every quarter to ensure ongoing adherence.

65f - Training Topics *(continued)*

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented (█ - 09/17/2025)

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:

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

Description of Violation

Staff person A did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, falls and accident prevention, and new population groups that are being served at the home that were not previously served, if applicable during training year 2024.

Staff person C did not receive training in resident rights, falls and accident prevention, and 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 (█ - 07/30/2025)***

All direct care staff retrained on 65g and was completed on 7/26/25
Schedule mandatory training sessions covering required topics (resident rights, mental illness, fire safety, infection control, dementia).
Utilize DHS-approved providers Temple University's Direct Care Staff Training Program.
Admin has developed a training calender.
For quality assurance the Administrator / Designee will audit training records every quarter to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented █ 09/17/2025)

85a - Sanitary Conditions

10. Requirements

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

Description of Violation

On █ at 9:47 AM, the toilets in both 3rd floor bathrooms were dirty with some type of unknown debris,

85a Sanitary Conditions (continued)

possibly feces or cigarette ashes.

On [redacted] at 8:35 AM, in bedroom [redacted] located on the second floor, there was a black substance that appeared to be mold around the window. The shower in the bathroom located on the second floor had a thick layer of brown grime on the floor. The faucet for the sink located in the same bathroom was caked with a white and grey substance that appeared to be limescale. The deep freezer in the front of the basement had a pungent odor of spoiled or rotten food.

Plan of Correction ***Accept ([redacted] - 07/30/2025)***

1. Immediate Remediation:
Affected areas and deep freezers were removed cleaned and disinfected on 6/5/25
Any contaminated or improperly used equipment was discarded or sanitized 6/5/2025
Staff Education:
All direct care and housekeeping staff received verbal and written instructions on sanitation standards 6/5/25
Training included infection control, equipment handling, and trash management 6/5/25
effective 06/06/25 ongoing deep cleaning will be implemented monthly by housekeeping/designee

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented [redacted] - 09/17/2025)

85b - Infestation

11. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On [redacted] at 9:35 AM, large rodent droppings were found all over the basement floor, including the area where emergency food is stored, and surrounding a freezer in the basement. There was also a swarm of large flies in the basement.

Plan of Correction ***Accept [redacted] - 07/30/2025)***

Basement floor was cleared of all droppings and fly activity using disinfectants and pest control treatments. All areas were addressed on 6/12/25
Affected areas were cleaned, disinfected, and sealed to prevent re entry immediately during the day of inspection, 6/12/25. Inspectors monitored to ensure all affected areas were cleaned to satisfaction .
All food and waste storage areas were inspected and reorganized 6/12/25
Staff Notification & Training:
All staff were informed of the violation and retrained on pest prevention protocols
Documentation & Reporting:
Pest control service reports and treatment logs were filed
A pest sighting log was created and placed in accessible staff areas. All findings must be reported to the administrator/designee immediately.
Preventive Measures
Weekly Environmental Inspections: starting 6/15/25
Conducted by maintenance/ staff or designee to identify entry points, moisture issues, or food debris.

85b Infestation (continued)

Sanitation Protocols:

Reinforced daily cleaning schedules and proper trash disposal

Professional pest control will come in on 8/1/25 to address all concerned areas going forward effective08/01/25 the professional pest control will come out on a monthly basis to treat the home to make sure that the home stays in compliance.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented ███ - 09/17/2025)

87 - Lighting

12. Requirements

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On ███ at 9:00 AM, the light in the hallway in front of bedroom 1A was inoperable.

Plan of Correction ***Accept (███ - 07/21/2025)***

On 06/12/2025 all residents' rooms were immediately inspected by the maintenance team to assess the presence and functionality of bedside lighting.

All inoperable lamps for residents were replaced with new, operable lamps and new batteries on June 13th, 2025.

Measure Prevent Recurrence:

A lighting checklist was implemented as a part of daily routine room inspections by the facilities maintenance staff to ensure all residents, hallways, outside steps, etc. are well lit and operable.

Licensee's Proposed Overall Completion Date: *07/20/2025*

Implemented ███ - 09/17/2025)

92 - Windows

13. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On ███ at 6:30 AM, the front window located on the right side of the porch has a crack the almost the length of the window. The window located near the left back entrance also has a crack in the window.

Plan of Correction ***Accept (███ - 07/30/2025)***

Immediate Repairs

Both damaged windows were assessed by maintenance staff on 06/12/2025

Replacement orders placed with licensed contractor; repairs scheduled for completion by 06/20/2025

All staff informed of the violation and reminded to report visible damage immediately

92 Windows (continued)

Preventive Measures
Maintenance/designee will do Monthly Window & Screen Inspections: starting on 7/12/25
All window damage reported to Administrator within 24 hours and addressed within 5 business days to ensure all: Windows and Screens Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented (█ - 09/17/2025)

95 - Furniture and Equipment

14. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The vanity in the 3rd floor bathroom, closest to the staircase, was in disrepair. One of the doors was slightly bent and protruding at the top. The bottom of the same door had paint peeling off the bottom.

Plan of Correction ***Accept █ - 07/30/2025)***

The damaged vanity door was removed and replaced with a new, fully functional door on 7/3/25
Fresh coat of paint was applied to the new door and surrounding cabinetry. 7/3/25
Preventive Measures:
Maintenance conducted a full inspection of bathroom vanities and fixtures building wide on 7/3/25
Scheduled replacement of any furniture components showing signs of wear, corrosion, or finish degradation will be ordered and installed as needed by the administrator/designee

Licensee's Proposed Overall Completion Date: *07/25/2025*

Implemented █ - 09/17/2025)

101j3 - Bed/Linens/Pillows/Blankets

15. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

101j3 - Bed/Linens/Pillows/Blankets *(continued)*

3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On [redacted], the bed for resident 6 had a blanket with multiple cigarette burn holes.

Plan of Correction ***Accept [redacted] - 07/30/2025)***

- Immediate Remediation:
- The damaged blanket was removed and replaced with a clean, undamaged blanket on June 12, 2025
- Resident #6 was informed along with all residents and offered additional bedding options for comfort 6/12/25
- Staff Notification & Training:6/12/25
- All direct care staff were reminded by administrator of the regulation and retrained on identifying and reporting damaged linens 6/12/25

Preventive Measures
- Monthly Linen Inspections:
Added to environmental checklist; staff/designee will inspect all resident bedding for cleanliness and damage
- Linen Replacement Protocol:6/12/25
Any item showing signs of wear (tears, stains, burns) to be replaced within 24 hours of identification

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented ([redacted] - 09/17/2025)

101j7 - Lighting/Operable Lamp

16. 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

On [redacted], several residents in rooms [redacted] do not have access to a source of light that can be turned on/off at bedside.

Repeat Violation:[redacted]

Plan of Correction ***Accept [redacted] - 07/30/2025)***

Immediate Remediation:
- Purchased and installed operable bedside lamps and batteries in all affected rooms on June 13, 2025
-Staff/maintenance verified functionality and accessibility for each resident 6/13/25
- All direct care and housekeeping staff were informed of the violation and on bedroom compliance standards 6/13/25
- Maintenance team instructed to include lighting checks in daily rounds 6/13/25
-administrator/designee will be notified immediately if any lights not operable in each room to ensure all residents

101j7 - Lighting/Operable Lamp (continued)

have operable lamps or other sources of lighting that can be turned on at the resident's bedside so they can be ordered and replaced within 24 hours.

Licensee's Proposed Overall Completion Date: *07/25/2025*

Implemented [redacted] - 09/17/2025)

101o - Walls, Floors, Ceilings

17. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On [redacted] the ceiling in room [redacted] was covered in small brown spots that appeared to be mold and dirt.

Plan of Correction ***Accept [redacted] - 07/30/2025)***

- Immediate Remediation:
- Maintenance staff cleaned and disinfected the affected ceiling area on June 12, 2025
- A licensed contractor assessed the ceiling and roof on June 14, 2025
- Mold remediation and ceiling resurfacing completed by June 17, 2025
- Staff Notification & Training:
- All staff were informed of the violation and retrained on identifying and reporting environmental hazards
- Maintenance team instructed to prioritize ceiling inspections in weekly rounds

Preventive Measures
- Monthly Environmental Inspections:
Include ceiling, wall, and floor conditions in all resident bedrooms
- Moisture Monitoring Protocol:
Maintenance staff to check for leaks, condensation, or discoloration during weekly rounds

Licensee's Proposed Overall Completion Date: *07/25/2025*

Implemented [redacted] - 09/17/2025)

103d - Storing Food Off Floor

18. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On [redacted] at 9:16 AM, boxes of green beans, fruit cups and cans of sweet corn were stored on the floor in the basement.

Plan of Correction ***Accept [redacted] - 07/30/2025)***

- Immediate Remediation:

103d - Storing Food Off Floor (continued)

- All food items were removed from the floor on June 12, 2025
- Basement area was cleaned and sanitized to eliminate contamination risk- Immediate Remediation: 6/12/25
- All food storage areas now maintain a minimum clearance of 6 inches from the floor 6/12/25
- Staff Training:
- Conducted training for dietary and housekeeping staff on proper food storage protocols on June 14, 2025
- Training included review of § 2600.103(d) and visual examples of compliant storage

- Storage Upgrade:
- All food storage areas now maintain a minimum clearance of 6 inches from the floor
- Staff Training:
- Conducted training for dietary and housekeeping staff on proper food storage protocols on June 14, 2025
- Training included review of § 2600.103(d) and visual examples of compliant storage

Preventive Measures
- Monthly Food Storage Inspections will be implemented on all incoming food deliveries by kitchen duty staff or designee.
- New Delivery Protocol:
All incoming food deliveries must be placed directly onto shelving or carts—never on the floor
- Annual Refresher Training:6/14/24
Reinforce food safety and storage regulations for all staff involved in food handling

Licensee's Proposed Overall Completion Date: *07/25/2025*

Implemented ███ - 09/17/2025)

103f - Refrigerator/Freezer Temps

19. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On ███, there was no thermometer in the freezer in the front of the basement.

Plan of Correction ***Accept███ - 07/30/2025)***

- Installed a freezer thermometer in the basement unit on June 12, 2025
- Verified freezer temperature was at or below 0°F and documented the reading 6/12/25
-Maintenace/staff Inspected all other refrigerators and freezers to confirm thermometer presence on 6/13/25
- Administrator/designee will review logs and inspect all refrigeration units for compliance+
- Thermometer Replacement Protocol
Damaged or missing thermometers to be replaced within 24 hours of identification.

Licensee's Proposed Overall Completion Date: *07/25/2025*

Implemented ███- 09/17/2025)

103i Outdated Food

20. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On [redacted] there were dented cans of Port Royal Red Kidney Beans and diced tomatoes located in the basement.

Plan of Correction ***Accept ([redacted] - 07/30/2025)***

- All dented cans were removed and discarded on June 12, 2025

- Basement food storage area was inspected for additional noncompliant items

- Administrator verified removal and sanitation of affected shelves along with inspector before they left.

- Staff Training:

- Dietary and housekeeping staff retrained on food safety standards by 08/13/2025

- Training included visual identification of dented cans and proper disposal procedures

Licensee's Proposed Overall Completion Date: *07/27/2025*

Implemented ([redacted] - 09/17/2025)

123c Evacuation Diagrams

21. Requirements

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 26 residents. However, there is no emergency evacuation diagram posted on the second floor on the 3410 side.

Plan of Correction ***Accept ([redacted] - 07/30/2025)***

-Administrator created and printed evacuation diagram for the second floor (3410 side) on June 13, 2025, and reposted. Copies of all of the building's diagrams were made and put in the office to be posted as needed.

- Diagram includes corridors, exit routes, fire extinguisher locations, and pull signals 6/13/25

- Posted in a clearly visible location throughout the entire building.6/13/25

- All staff retrained on requirements by June 15, 2025

Maintenance/staff will verify the presence and condition of evacuation diagrams on all floors weekly and report to the office immediately to replace all missing diagrams as needed.

Licensee's Proposed Overall Completion Date: *07/28/2025*

Implemented ([redacted] 09/17/2025)

131f Fire Extinguisher Inspection

22. Requirements

2600.

131f - Fire Extinguisher Inspection *(continued)*

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the basement has not been inspected by a fire safety expert since [redacted].

Plan of Correction ***Accept [redacted] 07/30/2025)***

On 6/5/25 The fire extinguisher was replaced immediately after the inspector brought it to the attention of the staff. All other fire extinguishers were checked for compliance by maintenance on 6/5/25. All fire extinguishers will be inspected monthly by maintenance/designee to ensure all extinguishers are up to date and operable. The fire extinguishers are due to be inspected annually in September 2025 the administrator/designee will reach out to the fire safety expert on or before 08/15/25 to schedule an appointment to have them inspected and tagged to make sure that the home remains in compliance.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented [redacted] - 09/17/2025)

141b1 - Annual Medical Evaluation

23. Requirements

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

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted]

Plan of Correction ***Accept [redacted] - 07/30/2025)***

On 7/11/25 the administrator contacted the PCP to schedule a home visit for 7/24/25 to obtain a current medical evaluation for resident [redacted] and all other residents in need of any required documents.
On 7/12/25 a tracking form has been implemented to monitor all required documents the administrator/designee/nurse will conduct the review quarterly of the charts to make sure that the home is in compliance.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented [redacted] - 09/17/2025)

144c1 - Smoking Area Guidelines

24. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

144c1 - Smoking Area Guidelines *(continued)*

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

Description of Violation

On [redacted] at 9:05 AM, bedroom 5c smelled like cigarettes and there were cigarette burn holes in resident [redacted] blanket.

Plan of Correction ***Accept ([redacted] - 07/30/2025)***

- Removed damaged blanket and replaced with clean, bedding on June 12, 2025

- Bedroom 5C thoroughly ventilated and inspected for fire hazards by maintenance and staff.6/12/25

- All Residents counseled on smoking policy and redirected to designated smoking area 6/13/25

- Monthly Fire Safety Audits: administrator/designee to inspect smoking areas and resident rooms for fire hazards and policy adherence monthly.

- Resident Education

All residents reminded of smoking rules and fire safety procedures during monthly community meetings on 7/17/25

Licensee's Proposed Overall Completion Date: *07/28/2025*

Implemented [redacted] - 09/17/2025)

162c - Menus Posted

25. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On [redacted], the posted menus in the home were dated for the weeks of [redacted] to [redacted].

Plan of Correction ***Accept [redacted] - 07/30/2025)***

A new monthly menu for June 2025 was prepared and posted on June 5, 2025, by the administrator.

Outdated menus removed from all public posting areas and reposted on 6/5/25 to reflect the correct dates for the month of June 2025. 6/5/25 Administrator verified that the menus were posted in the dining room and front sitting room.

Staff/designee will monitor daily to ensure all current menus are posted and will replace as needed

- Monthly Compliance Audit

administrator/designee to review menu logs and confirm visibility in designated areas.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented [redacted] 09/17/2025)

162c Menus Posted *(continued)*

162e - Menu Changes

26. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On [redacted], scrambled eggs, grits, beef scrapple, toast with butter, jelly, tea or juice were listed on the menu for the breakfast meal. Sugar puff cereal was served instead. No notice was provided to the residents in advance of the meal.

On [redacted], Italian hoagies or peanut butter and jelly, potato chips, juice or soda were listed on the menu for the lunch meal. Spaghetti with meat sauce was served instead. No notice was provided to the residents in advance of the meal.

Plan of Correction ***Accept [redacted] - 07/30/2025)***

A corrected menu was posted immediately upon discovery of the violation on 06/12/2025. The Administrator met with kitchen staff to review the incident and stress the importance of providing advance notice for any menu changes. Any changes to the menu will be posted in advance.
Residents were informed of the menu changes on the same day of the incident. Effective 06/13/2025 the administrator/designee will have a morning meeting every morning with the kitchen staff to go over the menu for the next day and if any changes are needed, we will make them at that time to give the resident's 24hrs notices.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented [redacted] - 09/17/2025)

183b - Meds and Syringes Locked

27. 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] at 7:30 AM, medications in the medication room were left unlocked, unattended, and accessible.

Plan of Correction ***Accept [redacted] - 07/30/2025)***

The medication room was immediately secured once the issue was identified on 6/12/2025. 6/12/25 The staff member responsible was retrained on medication storage protocols the same day, 06/12/2025. Administrator/Nurse performed an internal review of medication room security, confirming no medications were tampered with or removed on 6/12/25
Effective and starting on 06/13/205 CLS nurse will complete a daily audit verifying that all medication storage areas are properly secured.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented [redacted] - 09/17/2025)

183b - Meds and Syringes Locked *(continued)*

183d - Prescription Current

28. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On , the following medications were in the home's medication office:

- *and prescribed for resident*
- *and prescribed for resident*
- *and prescribed for resident*

These residents no longer reside in the home.

Plan of Correction ***Accept - 07/30/2025)***

on 06/12/25 the pharmacy was contacted in reference to medications needing to be returned for residents that is no longer is living in the home. 06/13/25 the pharmacy picked up the medications from the home effective immediately starting on 06/13/25 the nurse will be sure to check all the medications in the home daily to make sure there isn't any outdated medications or medications in the home that belongs to other resident's that no longer live in the home.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented - 09/17/2025)

185a - Implement Storage Procedures

29. 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

On the glucometer for resident was not calibrated with the correct time. At 7:13 AM, the glucometer read 7:58 AM.

Plan of Correction ***Accept - 07/30/2025)***

The home's nurse ordered a new glucometer from the PCP for Resident
- Glucometer time reset to match facility time standard on June 12, 2025
- Resident blood glucose records reviewed to ensure no documentation discrepancies
- Incident logged and reported to the Administrator
- Staff Training
- All medication administration staff retrained on § 2600.185(a) by June 15, 2025
- Training included proper use, calibration, and documentation procedures for glucometers and other medical devices

185a - Implement Storage Procedures (continued)

- Documentation

- Calibration log initiated for all glucometer

Effective on 06/13/25 the CLS nurse will check all glucometers to make sure that everything is working properly and calibrated correctly daily.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented [redacted] - 09/17/2025)

221a - Program Activities

30. Requirements

2600.
221.a. The administrator shall develop a program of activities designed to promote each resident's active involvement with other residents, the resident's family and the community.

Description of Violation

The home does not have a program of activities designed to promote the active involvement of residents with families and the community. Although there is an activities calendar posted, resident interviews revealed the home does not conduct activities.

Plan of Correction ***Directed ([redacted] - 07/30/2025)***

- Administrator revised the activity calendar to promote each resident. designee/staff to lead activities and document attendance on 06/23/25

all residents were encouraged and invited to participate in group bingo and music hour on June 23, 2025

- Program Development: Created a formal Resident Engagement Program with weekly social, recreational, and community-based activities

- Activities include family visitation events, community volunteer visits, movies and game activities.

- Posted updated calendar in dining room, lobby and verbal announcements.

On 06/13/25 a activities log was put in place for the residents to sign that they participated or didn't participate in the activities on a daily basis.

Proposed Overall Completion Date: 08/13/2025

Directed step of POC:

Within 5 days of receipt of the plan of correction: *The administrator shall interview two residents a week for three months to ensure activities which promote each resident's active involvement with other residents, the resident's family and the community is being offered. Documentation of interviews shall be kept.*

Directed Completion Date: *08/13/2025*

Implemented [redacted] 09/17/2025)

224a - Preadmission Screen Form

31. Requirements

224a - Preadmission Screen Form *(continued)*

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] was admitted to the home on [redacted]; however, the resident does not have a preadmission screening form.

Resident [redacted] preadmission screening form, dated [redacted] does not include the signature of the individual who completed the screening.

Plan of Correction ***Directed [redacted] 07/30/2025)***

The administrator/designee have completed preadmission screening on 6/15/25 for resident's [redacted] and [redacted] using the departments approved format. These preadmission screenings were conducted in consultation with each resident, family or representative to support their medical and service needs.
The homes admin/nurse has revised its admission protocol to require that an initial assessment is completed and signed within 15 days of admission, in order to be in full compliance with DHS 2600(224.a)
On 7/12/25 a Resident assessment, rasp and preadmission screenings new admissions tracking log has been implemented to monitor all new admissions.
The administrator/designee will conduct reviews for all new admissions within 5 days of the newly admitted residents to confirm that all preadmissions, assessments and rasps are completed and signed within the designated time the department requires. A monthly quality assurance meeting will include review of resident's assessment compliance and provide corrective steps for any lapses.
staff training to be completed by 7/30/25

Proposed Overall Completion Date: 07/26/2025

The above mention plan of correction is not acceptable.

Directed POC:

Immediately: *The administrator or designated staff person shall review all resident records to ensure all residents have a preadmission screening completed, including documentation that the home can meet the needs of the resident, and the Department's preadmission screening form is present in each resident record.*

Within 3 days of receipt of the plan of correction: *The administrator or designated staff person shall 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. Documentation shall be kept for review by the Department.*

Within 10 days of receipt of the plan of correction: *All staff persons involved with resident admissions shall be educated regarding the documentation system. Documentation of education shall be kept in accordance with 2600.65i.*

224a - Preadmission Screen Form (continued)

Directed Completion Date: *08/09/2025*

Implemented ███ - 09/17/2025)

225c - Additional Assessment

32. 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 ██ most recent assessment was completed on ██████.

Resident ██ most recent assessment was completed on ██████.

Plan of Correction ***Accept ███ - 07/30/2025)***

The administrator/designee have completed assessments on 6/15/25 for resident's ██ and ██ using the department's approved format. These assessments were conducted in consultation with each resident, family or representative to support their medical and service needs.
On 06/15/25 a Resident assessment tracking log has been implemented to monitor all required documents the administrator/designee will conduct the review quarterly of all the charts to make sure that the home is in compliance.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented ███ - 09/17/2025)

251a - Record for Each Resident

33. Requirements

2600.
251.a. A separate record shall be kept for each resident.

Description of Violation

The home does not have a record for resident ██.

Plan of Correction ***Accept ███ - 07/30/2025)***

A new record for resident's ██ was created by administrator on 6/12/25 using the departments approved format. An audit was conducted in consultation with each resident file.

The homes admin/nurse has revised its admission protocol to require that an initial chart is completed within 24 hours of admission, to be in full compliance with DHS. An extra copy was implemented to ensure all residents have their records at the home at all times.
On 7/12/25 a Resident assessment, rasp, and new admissions tracking log have been implemented to monitor all new admissions.

251a - Record for Each Resident (continued)

The administrator/designee will conduct reviews for all new admissions within 24 hours of the newly admitted residents to confirm that all charts are completed within their completion date.7/25/25 A monthly quality assurance meeting will include a review of residents' assessment compliance and provide corrective steps for any lapses.

Licensee's Proposed Overall Completion Date: *07/28/2025*

Implemented (- 09/17/2025)

252 - Record Content

34. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
   3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident s record does not include a photograph of the resident that is not more than 2 years old.

Plan of Correction ***Accept - 07/30/2025)***

Staff/nurse took photos for Resident on June 13, 2025
- Photo labeled with date and uploaded to digital record and printed for hard copy file
On 06/13/25 a tracking form has been implemented to monitor all required documents the administrator/designee will conduct the review quarterly of all the charts to make sure that the home is in compliance with making sure that each resident has an updated picture yearly.

Licensee's Proposed Overall Completion Date: *08/13/2025*

Implemented 09/17/2025)