pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **914 W MARKET STREET OPERATING COMPANY LLC**
LEGAL ENTITY

To operate **AUTUMN HOUSE OF YORK**
NAME OF FACILITY OR AGENCY

Located at **914 WEST MARKET STREET, YORK, PA 17401**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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

The total number of persons which may be cared for at one time may not exceed **132**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 20**

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

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

and shall remain in effect from **September 24,** **2025** until **March 24,** **2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **338221**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: SEPTEMBER 24, 2025

914 W Market Street Operating Company LLC
[redacted]

RE: Autumn House of York
914 West Market Street
York, PA 17401
License/COC #: 338221

Dear 914 W Market Street Operating Company LLC,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on June 10, 2025, June 11, 2025, August 20, 2025 and August 21, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 338220 dated June 26, 2025 until June 26, 2026, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (4) and 55 Pa. Code § 20.71(a)(2); (3) ;(4) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from SEPTEMBER 24, 2025 TO MARCH 24, 2026.

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

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
42(b)	II	91	$5	$455	5 calendar days from mailing date of this letter
187(d)	III	91	$3	$273	15 calendar days from mailing date of this letter

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

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

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

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

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

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *AUTUMN HOUSE OF YORK* **License #:** *33822* **License Expiration:** *06/26/2026*

Address: *914 WEST MARKET STREET, YORK, PA 17401*

County: *YORK* **Region:** *CENTRAL*

Administrator

Name: [redacted]

Legal Entity

Name: *914 W MARKET STREET OPERATING COMPANY LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/27/2000* **Issued By:** *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *122* **Waking Staff:** *92*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *06/11/2025*

Inspection Dates and Department Representative

06/10/2025 - On-Site: [redacted]

06/11/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *132* **Residents Served:** *93*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Laurel Court* **Capacity:** *20* **Residents Served:** *15*

Hospice

Current Residents: *16*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *92*

Diagnosed with Mental Illness: *13*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *29*

Have Physical Disability: *3*

Inspections / Reviews

06/10/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/13/2025*

07/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/07/2025*

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

07/22/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/07/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/06/2025*

09/17/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/07/2025*

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

17 - Record Confidentiality

1. 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 6/10/25 at approximately 10:30 AM, a list of resident information for residents #1, #2, and #3 was unlocked, unattended, and accessible in a cabinet in the 3000 hallway of the home. Resident information included care needs for mobility, room numbers, and shower schedules.

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

1. On 6/10/25, the assignment sheet found unattended and accessible was immediately secured by the administrator during the walkthrough with DHS surveyors.
2. On 6/10/25, a complete walkthrough of the building was conducted by DHS surveyors and the building administrator, and no other resident records or protected information was found to be left unattended or accessible to anyone other than authorized persons.
3. Re-education was provided to staff on 6/25/2025 by the administrator to ensure the importance of HIPAA and protecting resident's sensitive information. Re-education will continue by administrator or designee on 7/11/25 and 8/20/25 at monthly staff meetings.
4. An audit/walkthrough of the building will be completed by the administrator or designee weekly for four weeks beginning 7/7/2025, then monthly for two months beginning August 2025 to monitor ongoing compliance with 2600.17. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented [redacted] - 09/09/2025)

42b - Abuse

2. 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 [redacted]/25 at approximately 7:30 PM, resident #4 wandered into resident #5's bedroom. Resident #5 pushed resident #4 down, causing resident #4 to hit their head.

On [redacted]25 at 5:49 PM, resident #4 wandered into resident #6's bedroom. Resident #6 slapped resident #4 in the face multiple times and shoved resident #4 into a bed. As a result, resident #4 had complaints of back pain and was assessed by hospice nursing.

On [redacted]25 at approximately 7:50 PM, resident #7 hit resident #8 with a decorative rock found in another resident's room. Contact was made to resident #8's upper back causing a reddened area on resident #8's back.

42b - Abuse (continued)

Repeated Violation - 1/14/25, 11/6/24 et al., 7/22/24, et al.

Plan of Correction ***Accept [redacted] - 07/22/2025)***

1. Regarding reported resident to resident incidents:
a. On [redacted]/25, post incident staff separated and assessed the residents who both live on the secured dementia unit, vitals were stable and hospice, PCP, and POAs were notified. No ill effects were noted at that time. Area on Aging, notified via phone call on 2/12/2025 and ACT 13 faxed on 2/12/25, DHS notified via reportable incident form on 2/12/2025 by Dementia Program Director.
b. On 4/13/25, post incident staff separated and assessed the residents who both live on the secured dementia unit. POAs, PCPs and Hospice were notified. One resident complained of back pain and hospice came out to assess. Area on Aging, notified via phone call on 4/14/25, and ACT 13 faxed on 4/14/25, DHS notified via reportable incident form on 4/14/25 by Resident Care Coordinator.
c. On 5/9/25, staff separated and assessed the residents who both live on the secured dementia unit. POAs, PCPs and hospice were notified. One resident had a reddened area on their back but it went away. No ill effects noted. Area on Aging notified via phone call on 5/9/25, ACT 13 form faxed 5/10/25 and DHS notified via reportable incident form on 5/10/2025 by Administrator.
2. On the above dates all other residents were provided care per their individual resident assessment and support plans.
3. Re-education to nursing staff (med techs and direct care staff) will take place on 7/23/25 by Resident Care Coordinator and Administrator regarding regulation 2600.42b and the importance of 30-minute checks in the secured memory care unit to ensure the residents are kept as safe as possible and to eliminate or minimize altercations whenever possible. Staff will also be re-educated on 7/23/25 by Resident Care Coordinator and Administrator to document effectively and report concerns regarding resident behaviors to supervisors, PCPs, and family members so that issues can be properly addressed as quickly as possible. The assessments and support plans for residents #4, #6, and #7 will be reviewed by the Director of Wellness or designee and updated for current needs and supports, specifically the areas of behaviors and supervision by August 1, 2025. The Director of Wellness and administrator or designee will determine if the home can meet the updated needs of each of the residents by August 5, 2025. The administrator or designee will schedule a training with an outside source for nursing staff (med techs and direct care staff) on a topic specific to dementia training and de-escalation training by September 1, 2025. Resident # 5 no longer resides at the facility.
4. An audit of nursing notes will be completed weekly times four weeks beginning 7/7/2025, and then monthly times two months beginning August 2025 by administrator or designee to ensure incidents are properly addressed, documented and reported. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

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

42c - Treatment of Residents

3. Requirements

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

Description of Violation

On [redacted]/25, resident #4 was found in another residents bedroom eating feces off of the floor.

Plan of Correction ***Accept [redacted] - 07/22/2025)***

1. At time of incident staff assisted resident with oral care and personal hygiene. Staff notified PCP and hospice. No ill effects noted.
2. Resident resides on the secured dementia unit. All residents on the secured dementia unit are checked every 30 minutes for safety purposes unless otherwise noted in their resident assessment and support plan.
3. Re-education to nursing staff (med techs and direct care staff) will take place on 7/23/25 by Resident Care Coordinator and Administrator regarding regulation 2600.42c and the importance of 30-minute checks in the secured memory care unit for safety purposes and to maintain dignity and respect for the residents. Staff will also be re-educated on 7/23/25 by Resident Care Coordinator and Administrator to document effectively and report concerns regarding resident's behaviors to supervisors, PCP's, and family members so that issues can be properly addressed as quickly as possible. Resident # 4's assessment and support plan will be reviewed and updated by the Director of Wellness or designee by August 1, 2025, specifically regarding behavior and supervision. A determination will be made by August 5, 2025 by the administrator and director of wellness or designee whether the home can meet the needs of resident # 4. All residents on the secured dementia care unit receive 30 minute checks for safety purposes. Residents who require toileting assistance are on a 2-hour toileting schedule to be proactive and avoid incontinence episodes whenever possible.
4. An audit of nursing notes will be completed weekly times four weeks beginning 7/7/25 and then monthly times two months beginning August 2025 by administrator or designee to ensure incidents are properly addressed, documented and reported. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/05/2025*

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

81b - Resident Personal Equipment

4. Requirements

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

Description of Violation

On 6/10/25 at 10:06 AM, resident #9's bathroom shower chair wobbled loosely, approximately 2" from side to side, creating a potential safety hazard.

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

1. A work order was placed on 6/10/2025 by the administrator for maintenance to tighten the chair in resident #9's bathroom. The device was tightened by maintenance on 6/11/2025. No ill effects noted.
2. An audit was completed of all other devices in resident rooms on 6/12/2025 and no other issues were found with loose chairs.

81b - Resident Personal Equipment (continued)

3. Re-education was provided to staff on 6/25/2025 by the administrator to ensure any concerns with resident's equipment are reported in a timely manner so a work order can be placed and the item can be fixed or replaced as quickly as possible for safety. Re-education will continue at monthly staff meetings on 7/16/25 and 8/20/25 to all staff by administrator or designee.
4. An audit/walkthrough of the building will be completed by the administrator or designee weekly for four weeks beginning 7/7/25, then monthly for two months beginning August 2025 to monitor ongoing compliance with 2600.81b. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

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

82c - Locking Poisonous Materials

5. Requirements

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

Description of Violation

On 6/10/25 at approximately 10:50 AM, the following items were unlocked, unattended and accessible in resident #4's bathroom.

- *A box of Efferdent Plus with a manufacturer's label indicating, "Keep out of reach of children" and "in case of accidental ingestion, contact poison control center immediately,"*
- *A bottle of nail polish remover with a manufacturer's label indicating "harmful if ingested, in case of accidental ingestion, give fluids liberally and consult with local poison control,"*

Resident #4's assessment and support plan, dated [redacted]/24, indicated that the resident is unable to use and avoid poisonous materials.

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

1. The Efferdent Plus and bottle of nail polish remover were removed from the unlocked cabinet in Resident #4's bathroom on 6/10/25 and secured by nursing staff.
2. An audit was completed on 6/11/25 by nursing staff of all resident rooms on the secured dementia care unit to ensure poisonous materials were not accessible to residents.
3. Re-education was provided to staff on 6/25/2025 by the administrator to ensure poisonous materials are not accessible to residents who are not deemed safe to use and avoid them. Re-education will continue at monthly staff meetings on 7/16/25 and 8/20/25 regarding 2600.82c to all staff by administrator or designee.
4. An audit/walkthrough of the building will be completed by the administrator or designee weekly for four weeks beginning 7/7/2025, then monthly for two months beginning August 2025 to monitor ongoing compliance with 2600.82c. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

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

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

On 4/10/25 at 10:49 AM, resident #10s glucometer was used to check resident #11's blood glucose level
On 4/10/25 at 12:39 PM, resident #11's glucometer was used to check resident #10's blood glucose level.

On 6/10/25 at approximately 10:50 AM, resident room 2106 had a pungent, ammonia odor. The carpet directly beside the bed had a dark brown stain measuring about 3' by 3'. In front of the mini-refrigerator in the room were smaller red stains approximately 6" by 6" and smaller.

On 6/10/25 at approximately 10:50 AM, there was a strong odor of urine in Laurel Court resident room 11.

On 6/10/25 at approximately 10:55 AM, the common shower room in Laurel Court had the following unsanitary conditions:

- *A used hygiene wipe in a basket.*
- *An unlabeled electric razor that was covered in hair and debris in an unlabeled basket.*

Plan of Correction ***Directed [redacted] - 07/22/2025)***

1. For the glucometer incident:
a. On 4/10/25 both resident's glucometers were replaced as soon as [redacted] received report of the error. One [redacted] was present and time of error, the other was notified and PCP's were notified by nursing staff on 4/10/2025. No recommendations were given from either PCP. and DHS reportable incident was completed via fax.
b. All other glucometers were audited by nursing staff on 4/11/25 to ensure they were not being used for anyone other than who they were labeled and intended for. No issues noted.
c. Re-education on infection control was provided to the med tech who created the error by the Director of Wellness during error reporting on 4/11/25. Resident # 11 and their designated person will be notified via letter of the shared glucometer use in the facility and the possibility of blood borne diseases. Copies of the letter will be maintained by the administrator or designee. Resident #10 is [redacted] Several med techs received updated diabetic training on June 2, 2025. The director of wellness or designee will schedule all other med techs for diabetic re-certification as soon as possible.
d. A glucometer audit will be conducted monthly times three months beginning in July 2025 by the Director of Wellness or designee to monitor compliance. Glucometer audits have been in place for several years on a monthly basis and are schedule to occur the first week of every month. The results of these audits will be kept by the

85a - Sanitary Conditions (continued)

administrator and used during Quality Assurance/Improvement meetings for review and recommendations.
2. Regarding odors and unsanitary conditions:
a. The resident residing in room 210 was moved to another room by housekeeping and the carpet was replaced by [redacted] flooring on 6/23/25. The used and unlabeled items located in the secured dementia care unit were discarded. The food debris on the counters and floors were cleaned immediately by the dietary director on 6/10/2025. A thorough cleaning of the kitchen was completed by the dining director on 6/21 and 22, 2025. The plastic gallon sized container of honey mustard dressing was thrown away by the dining director on 6/10/2025. The odor in room LC11 was addressed with housekeeping thoroughly cleaning the room on 6/12/2025. The resident in 2106 receives total physical assistance with toileting and incontinence care by direct care staff.
b. An audit/building walkthrough was conducted by the administrator and marketing director on 6/13/25 and any flooring that was identified as needing replaced was reported to [redacted] for scheduling and replacement. Any areas identified as needing a thorough cleaning was also identified and addressed by housekeeping. The housekeeping director does random room audits weekly and adjusts cleaning schedules or carpet cleanings as needed.
c. Re-education was provided to staff on 6/25/2025 by the administrator to ensure any concerns with the cleanliness of resident's rooms or common areas are reported in a timely manner so that issues are addressed by housekeeping, maintenance and/or administration in a timely manner and regarding keeping the kitchen free of food debris when not prepping food during meal times. Re-education will continue at monthly staff meetings on 7/16/25 and 8/20/25 to all staff by administrator or designee.
d. An audit/walkthrough of the building, including the kitchen, will be completed by the administrator or designee weekly for four weeks beginning 7/7/2025, then monthly for two months beginning August 2025 to monitor ongoing compliance with 2600.85a. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

(Directed)
In addition to the above plan of correction:

- *All staff responsible for blood sugar testing will receive re-training from a certified diabetic educator. The training date will be confirmed no later than 8/5/25.*
- *A glucometer audit will be conducted monthly times three months beginning no later than 7/28/5.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department. The audits will include identified of concern found as well as the plan to correct each area.*

Directed Completion Date: *08/01/2025*

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

85b - Infestation

7. Requirements

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

Description of Violation

On 6/10/25, there was evidence of a mouse infestation in the home with significant mouse droppings located in the corner of the kitchen. Resident interviews indicated sightings of mice throughout the home.

85b - Infestation *(continued)*

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

1. On 6/21 and 22, 2025 the dining director thoroughly cleaned and organized the kitchen. On 5/29/2025, the administrator increased the contract with Ehrlich, professional pest control company to effectively address any mice or pest concerns noted in the building. Pest control visits were increased from once monthly to twice monthly to assess and treat indoors and outdoors, or more as needed.
2. During the walkthrough on 6/10/25 with surveyors this was the only area identified as having evidence of mice.
3. Re-education was provided to staff on 6/25/2025 by the administrator to ensure any concerns with the cleanliness of resident's rooms, common areas, or evidence of pests are reported in a timely manner so that issues are addressed by housekeeping, maintenance and/or administration in a timely manner. Re-education will continue at monthly staff meetings on 7/16/25 and 8/20/25 to all staff by administrator or designee. A note was placed in the monthly resident newsletter that goes out to all residents and families to please keep food items in sealed containers to assist in keeping pests out of the facility.
4. An audit/walkthrough of the building will be completed by the administrator or designee weekly for four weeks beginning 7/7/2025, then monthly for two months beginning August 2025 to monitor ongoing compliance with 2600.85b. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

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

85d - Trash Receptacles

8. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 6/19/25 at approximately 10:30 AM, there were two uncovered, unattended trashcans in the main kitchen containing food; there was no meal being served at the time.

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

1. The trash cans were properly covered after DHS surveyors indicated they were uncovered and unattended during walkthrough on 6/10/2025 by dining director.
2. An audit was conducted on 6/13/2025 by administrator to ensure the proper amount of trash can lids were available in the kitchen for staff to utilize lids when the trashcans are unattended. No other concerns were noted at that time.
3. Re-education was provided by administrator to the dining director on 6/13/2025 regarding 2600.85d. Re-education was provided to staff on 6/25/2025 by the administrator to ensure staff are aware of requirement to keep trash in kitchens and bathrooms covered when unattended for pest control purposes. Re-education will continue at monthly staff meetings on 7/16/25 and 8/20/25 to all staff by administrator or designee.
4. An audit/walkthrough of the building, including the kitchen, will be completed by the administrator or designee weekly for four weeks beginning 7/7/2025, then monthly for two months beginning August 2025 to monitor ongoing compliance with 2600.85d. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

85d - Trash Receptacles *(continued)*

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented [redacted] - 09/09/2025)

101j7 - Lighting/Operable Lamp

10. Requirements

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

Description of Violation

Resident #4 did not have access to a source of light that can be turned on/off at bedside.

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

1. A lamp was placed at the bedside on 6/11/2025 by maintenance.
2. A walkthrough of the building by administrator and sales/marketing director on 6/13/2025 was completed and found no other lamps missing at bedsides.
3. Re-education was provided by administrator to maintenance on 6/13/2025 regarding regulation 2600.101j that all bedrooms must have an operable lamp or other source of lighting that can be turned on at bedside.
4. An audit/walkthrough of the building will be completed by the administrator or designee weekly for four weeks beginning 7/7/2025, then monthly for two months beginning August 2025 to monitor ongoing compliance with 2600.101j. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

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

102i - Soap Dispenser

11. Requirements

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

Description of Violation

On 6/10/25 at approximately 11:29 AM, there were two unlabeled, used bars of soap on the sink in the common bathroom adjoining resident rooms 118 and 120.

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

1. On 6/11/2025 the two unlabeled, used bars of soap on the sink in the common bathroom adjoining resident rooms 118 and 120 were thrown away for infection control purposes. Liquid soap was replaced in the bathroom at that time by administrator.
2. During the walkthrough on 6/10/2025 with DHS surveyors, administrator no other bathrooms with bar soap present.
3. Re-education was provided by administrator to the housekeeping director on 6/13/2025 regarding 2600.102i. Re-education was provided to staff on 6/25/2025 by the administrator to ensure staff are aware that bar soap is not permitted unless a separate bar is clearly labeled for each resident who shares a bathroom. Re-education will continue at monthly staff meetings on 7/16/25 and 8/20/25 to all staff by administrator or designee.

102i - Soap Dispenser (continued)

4. An audit/walkthrough of the building will be completed by the administrator or designee weekly for four weeks beginning 7/7/2025, then monthly for two months beginning August 2025 to monitor ongoing compliance with 2600.102i. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented [redacted] - 09/09/2025)

103g - Storing Food

12. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 6/10/25 at approximately 10:34 AM, a bag of diced carrots, a bag of dinner rolls, and a box of pot pie in the freezer were opened and unsealed. A box of oatmeal cookies in the refrigerator was opened and unsealed.

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

1. On 6/10/2025 all improperly stored food items were immediately discarded or transferred into sealed, labeled containers by the dining director.
2. A complete walkthrough of the kitchen on 6/10/2025 by DHS surveyors and administrator yielded no other opened and unsealed foods other than what is listed.
3. Re-education was provided by administrator to the dining director on 6/13/2025 regarding 2600.103g. Re-education was provided to staff on 6/25/2025 by the administrator to ensure staff are aware food shall be stored in closed or sealed containers. Re-education will continue at monthly staff meetings on 7/16/25 and 8/20/25 to all staff by administrator or designee.
4. An audit/walkthrough of the building will be completed by the administrator or designee weekly for four weeks beginning 7/7/2025, then monthly for two months beginning August 2025 to monitor ongoing compliance with 2600.103g. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

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

132a - Monthly Fire Drill

13. Requirements

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

Description of Violation

An unannounced fire drill was not held during the month of March 2025.

Plan of Correction ***Accept ([redacted] - 07/22/2025)***

1. Since March 2025, when the unannounced fire drill was missed, an unannounced fire drill has been held each

132a - Monthly Fire Drill (continued)

month by the maintenance director at varied times, and on varied days and dates.
2. A fire drill schedule was created on 7/1/2025 for the entire calendar year, by the administrator, to which only the maintenance director and administrator will have knowledge of to ensure drills are held in accordance with regulatory compliance and unannounced.
3. Re-education provided to the maintenance director by the administrator on 6/13/2025 regarding 2600.132a.
4. An audit of the documentation of each drill will be conducted monthly for three months beginning July 25, 2025 by the administrator to ensure compliance with 2600.132a. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented [redacted] - 09/09/2025)

132e - Fire Drill Sleeping Hours

14. Requirements

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

Description of Violation

The last fire drill conducted during sleeping hours was on 8/22/24 at 4:30 AM.

Plan of Correction ***Accept [redacted] - 07/22/2025)***

1. An unannounced fire drill was conducted by the maintenance director during sleeping hours on 6/24/25 at approximately 4:50am.
2. A fire drill schedule was created on July 1, 2025 for the entire calendar year, by the administrator, to which only the maintenance director and administrator will have knowledge of to ensure drills are held in accordance with regulatory compliance, unannounced, and held during sleeping hours once every 6 months.
3. Re-education provided to the maintenance director by the administrator on 6/13/2025 regarding 2600.132e.
4. An audit of the documentation of each drill will be conducted monthly for three months beginning July 25, 2025 by the administrator to ensure compliance with 2600.132e. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented [redacted] - 09/09/2025)

141b1 - Annual Medical Evaluation

15. Requirements

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

Description of Violation

Resident #9's most recent medical evaluation was completed on [redacted]/23.

Resident #12's most recent medical evaluation was completed on [redacted]/25. The resident's previous medical evaluation was completed [redacted]24.

141b1 - Annual Medical Evaluation *(continued)*

Plan of Correction ***Directed [redacted] - 07/22/2025)***

1. Resident #9 and Resident #12 see providers who do not come to the facility and it has been difficult to get evaluations and forms completed per regulatory requirements. The Director of Wellness begins reaching out to providers and families regarding the need for a medical evaluation approximately 3 months in advance so that evaluations can be scheduled in a timely manner and completed per regulatory requirements. Resident # 9 and family decided to change providers to an in-house physician due to inability to get compliance from current provider to complete a medical evaluation and necessary DME form for regulatory compliance. New DME was completed on 6/19/2025.

2. An audit of current DME's will be completed by 8/1/2025 by administrator or designee to ensure all DME's are up to date.

3. Director of Wellness or designee will document all attempts made while attempting to get medical evaluation appointments scheduled and any reasons for non-compliance in the future. The home will review the current policies and procedures related to resident medical evaluations and provide updates on the process if an evaluation is not being scheduled timely and the reason why. When policy updates occur all necessary staff persons will be educated by the director of wellness, administrator or designee.

4. A random audit of 5 resident's DMEs will be conducted monthly for three months beginning in August 5, 2025 by the administrator or designee to ensure ongoing compliance of 2600.141b1. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

(Directed)

In addition to the above plan of correction, the policy and procedures related to resident medical evaluations will be reviewed by the Administrator or designee no later than 7/31/25 for necessary updates. All staff responsible for completing medical evaluations for residents will receive education on the updated policy and procedure by 8/5/25.

Directed Completion Date: *08/05/2025*

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

142a - Secure Medical Care

16. Requirements

2600.
142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

Resident #9's assessment, completed [redacted]/24, indicated the resident requires total physical assistance from direct care staff or family to manage and secure health care, secure and use transportation, and to make and keep appointments. On [redacted]/25 at 10:01 AM, resident #9 approached staff and stated [redacted] wanted to go to the hospital. The staff told resident that they are on hospice, and the staff will have to call hospice if something is wrong unless it is an emergency. The resident informed staff he was dizzy and the room was spinning. The staff explained to the resident why they couldn't go to hospital and administered the resident's PRN Lorazepam. The resident was instructed to get a cold washcloth, put it on [redacted] forehead or behind [redacted] neck while in [redacted] recliner, put on his oxygen for extra support and close [redacted] eyes and relax. The home did not document a report to the resident's family, physician or hospice agency nor whether medical care was secured.

142a - Secure Medical Care (continued)

Plan of Correction ***Accept[redacted] - 07/22/2025)***

1. Resident #9 is on hospice services and it is normal protocol to call hospice if a resident has a concern or incident. However, the resident asked to be sent to the hospital and should have received the assistance to do so from staff at that time.
2. Staff Member A no longer works at the facility as of [redacted]/2025.
3. Re-education will take place on 7/23/25 by the administrator and resident care coordinator to ensure all nursing staff (med techs and direct care staff) understand that they are to assist residents in obtaining emergency services prior to contacting hospice unless their current ailment is the reason the resident is receiving hospice services.
4. An audit of nursing notes will be completed weekly times four weeks beginning 7/7/25 and then monthly times two months beginning August 2025 by administrator or designee to ensure incidents are properly addressed, documented and reported. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

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

183b - Meds and Syringes Locked

17. 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 6/10/25 at approximately 10:08 AM, Protect zinc oxide paste skin protectant and Cavilon durable barrier cream, were unlocked, unattended, and accessible in resident #4's bedroom. Resident #4 is not assessed to self-administer medications as indicated on the resident's medical evaluation, dated [redacted]/24.

On 6/10/25 at approximately 10:07 AM, Walgreens cold sore treatment and Desitin daily defense cream were unlocked, unattended, and accessible in resident #9's bedroom. Resident #9 is not assessed to self-administer medications as indicated on the resident's medical evaluation, dated [redacted]/23.

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

1. Protect Zinc Oxide skin protectant, Cavilon durable barrier cream, Walgreens Cold Sore Treatment, and Desitin daily defense cream were secured on 6/10/25 by nursing staff so that residents did not have access to the medications.
2. During the walkthrough with DHS surveyors on 6/10/25 no other medications were found unsecured in resident's rooms.
3. Re-education will be provided to nursing staff on 7/23/25 by administrator and resident care coordinator to promote ongoing compliance with ensuring all medications are kept in a secured location away from residents who do not have orders to self-store/self-administer.
4. A walkthrough of the building will be completed by the administrator or designee weekly for four weeks

183b - Meds and Syringes Locked (continued)

beginning 7/7/2025, then monthly for two months beginning August 2025 to monitor ongoing compliance with 2600.183b. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented [redacted] - 09/09/2025)

184a - Resident's Meds Labeled

18. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for resident #9's Haloperidol did not include the resident's name, prescribed dosage and instructions for administration or the name and title of the prescriber.

Repeated Violation - 11/6/2024, et al

Plan of Correction ***Accept [redacted] - 07/22/2025)***

1. Haloperidol for resident #9 was removed from the medication cart by nursing staff and properly disposed of with two staff present on 6/12/2025. A new supply was re-ordered on 6/11/2025 from the pharmacy by nursing staff and was delivered on 6/12/2025 so that a properly labeled supply was present and available for safe medication administration.
2. Medication Carts were audited on 7/3/2025 by nurse management and pharmacy during cycle fill changeover and no other medications were found to be improperly labeled.
3. Re-education to nursing staff (med techs and direct care staff) will take place on 7/23/25 by administrator and resident care coordinator regarding the proper medication labeling requirements of 2600.184a.
4. A medication cart audit will be completed by the director of wellness or designee monthly for three months starting in July 25, 2025 to monitor ongoing compliance with 2600.184a. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented [redacted] - 09/09/2025)

184b - Labeling OTC/CAM

19. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

184b - Labeling OTC/CAM *(continued)*

Description of Violation

On 6/10/25 at approximately 10:48 AM, a tube of Zinc Oxide Paste Skin Protectant and Cavilon Durable Barrier Cream belonging to resident #4 was in the resident's bathroom and was not labeled with the resident's name.

On 6/10/25 at approximately 10:08 AM, a tube of Walgreens cold sore treatment and tube of Desitin daily defense belonging to resident #9 was in the resident's bathroom and was not labeled with the resident's name.

On 6/10/25 at approximately 11:18 AM, a bottle of Antifungal powder belonging to resident #13 was in the resident's bathroom and was not labeled with the resident's name.

On 6/10/25 at approximately 10:15 AM, a tube of Voltaren cream and Kirkland arthritis pain gel belonging to resident #14 was in the resident's bathroom and was not labeled with the resident's name.

Repeated Violation - 1/14/25, 11/6/24 et al

Plan of Correction ***Accept [redacted] - 07/22/2025)***

1. The Zinc Oxide Paste Skin Protectant, Cavilon Durable Barrier Cream, Walgreens cold sore treatment, Desitin daily defense, antifungal powder, Voltaren cream, and Kirkland's arthritis pain gel were properly labeled by nursing staff on 6/11/2025
2. An audit was completed on 6/13/2025 by the administrator of all resident rooms on the secured dementia care unit to ensure no poisonous materials were accessible to residents.
3. Re-education to nursing staff(med techs and direct care staff) will take place on 7/23/25 by administrator and resident care coordinator on the importance of labeling OTC medications with the resident's name for safety purposes.
4. A medication cart audit will be completed by the director of wellness or designee monthly for three months starting July 3, 2025 to monitor ongoing compliance with 2600.184b. A walkthrough of the building will be completed by the administrator or designee weekly for four weeks beginning 7/7/25, then monthly for two months beginning August 2025 to monitor ongoing compliance with 2600.184b. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

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

185a - Implement Storage Procedures

20. 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 #4 is prescribed Lorazepam 1 tablet by mouth every 6 hours as needed for anxiety or agitation. On 6/11/25 at approximately 4:00PM, this medication was not present in the cart.

185a - Implement Storage Procedures (continued)

Repeated Violation - 1/14/25, 11/6/24 et al.

Plan of Correction ***Accept (- 07/22/2025)***

1. Resident #4's lorazepam was ordered by nursing staff on 6/12/2025 from the pharmacy and it was delivered on 6/13/2025. Resident #9's morphine was tightened and the bottle cleaned. The medication was re-calibrated/counted by two staff on 6/13/2025 to ensure the narcotic count was correct and medication was available for administration.
2. All other medication carts were checked by nursing staff on 6/10/2025 during shift change/narcotic count to ensure morphine bottles were secured properly.
3. Re-education will take place to nursing staff (med techs and direct care staff) on 7/23/25 by administrator and resident care coordinator regarding 2600.185a and the procedures for safe storage of medications.
4. A medication cart audit will be completed by the director of wellness or designee monthly for three months starting in July 3, 2025 to monitor ongoing compliance with 2600.185a. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Not Implemented (- 09/09/2025)

186a - Authorized Prescriber

21. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

On 4/20/25 at 10:01 AM, staff member A administered PRN Lorazepam to resident #9. A Lorazepam PRN order was not prescribed by an authorized prescriber at the time of administration.

Plan of Correction ***Accept - 07/22/2025)***

1. Resident #9 had a routine every 6 hours lorazepam order but no PRN order. Staff member A documented in nursing notes giving resident #9 a PRN lorazepam but no documentation in MAR as there was no order.
2. Staff member A no longer works at the facility as of /2025. All med techs are educated to the PA Medication Administration Training by a certified Trainer.
3. Re-education will take place on 7/23/25 to all nursing staff by administrator and resident care coordinator regarding following proper medication administration and storage requirements.
4. An audit of nursing notes will be completed weekly times four weeks beginning 7/7/2025, and then monthly times two months beginning August 2025 by administrator or designee to ensure anything noted as being given PRN has an order and is documented properly on the MAR. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented - 09/09/2025)

186a - Authorized Prescriber *(continued)*

187b - Date/Time of Medication Admin.

22. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #4 is prescribed Acetaminophen 650mg 1 suppository per rectum every 6 hours as needed for mild pain. Resident #4's May 2025 medication administration record does not include staff member B's initials, who administered Acetaminophen on 5/26/25.

Plan of Correction ***Accept [redacted] 07/22/2025)***

1. Resident #4 was given prn acetaminophen 650mg suppository as ordered, however documentation was not completed properly. An order was obtained on 6/9/2025 as resident is still able to tolerate by mouth medications at this time.
2. Re-education provided to Staff Member B on 6/13/2025 in the importance of documenting immediately after medication administration for safety purposes.
3. Re-education will take place on 7/23/25 to all nursing staff (med techs and direct care staff) by administrator and resident care coordinator regarding following proper medication administration, including documentation and storage requirements.
4. An audit of nursing notes will be completed weekly times four weeks beginning 7/7/2025, and then monthly times two months beginning August 2025 by administrator or designee to ensure anything noted as being given PRN is documented properly on the MAR. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

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

187c - Refusal of Medication

23. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 5/14/25 at 12:00 PM and on 5/27/25 at 4:00 PM and 8:00 PM, resident #9 refused to take a scheduled dose of Morphine. The home did not report the refusal to the prescriber.

Plan of Correction ***Accept [redacted] - 07/22/2025)***

1. Resident #9 is on hospice services. Staff must document reporting to the physician even if verbal reports are made to hospice staff while they are in the facility.
2. A medication record audit for all MARs in June 2025 was completed on July 10, 2025 by the administrator to ensure any medications that were documented as REFUSED were documented and reported appropriately.

187c - Refusal of Medication (continued)

3. Re-education will be provided to all nursing staff (med techs and direct care staff) on 7/23/25 by the administrator and resident care coordinator to ensure staff are aware of proper procedures reporting and documenting refusals of medications and re-attempts made.
4. An MAR audit will be conducted monthly times three months beginning August 5, 2025 by the administrator or designee to ensure ongoing compliance with 2600.188b. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/05/2025*

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

187d - Follow Prescriber's Orders

24. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #9 is ordered to have [redacted] weight taken every month. The administration records from February 2025-May 2025 indicate the resident was either sleeping or refused. Staff reported it is not completed because it is difficult to weigh the resident standing independently on the scale for an accurate measurement. There is no documentation that staff re-attempted administration at a later time or attempted to rouse the resident. These events were not communicated to the prescriber. The last documented weight in the home's medication administration record system is 4/4/24.

Resident #9 is prescribed Lorazepam 0.25mL by mouth every 6 hours routine. This medication was not administered as follows:

- *6/8/25 at 11:43 AM*
- *6/7/25 at 6:32 AM*
- *6/5/25 at 12:24 PM*
- *6/3/25 at 11:38 AM.*

Resident #9 was prescribed Morphine 0.25ML by mouth 3 times daily effective 2/6/25. On 2/19/25 at 2:00 PM, staff did not administer the resident's Morphine because there was no syringe to draw the medication.

Resident #9 was prescribed Morphine 0.25ML by mouth every 4 hours around the clock effective 3/5/25. The medication was not administered as follows:

- *3/11/25 at 4:00 PM due to staff being unable to get the morphine into the syringe.*
- *From 4/24/25 at 8:00 AM through 4/25/25 at 4:00 PM as the medication was not available in the home.*

Resident #10 is prescribed Insulin Aspart 3 units 3 times daily with meals in addition to sliding scale as follows: 71-150=7UI, 151-200=9UI, 201-250=11UI, 251-300=13UI, 301-350=15UI, more than 350=17UI. On 6/6/2025 at 12:07

187d - Follow Prescriber's Orders (continued)

PM, the resident had a blood glucose reading of 268 and only 13 units of Glargine Insulin were administered.

Repeated Violation - 1/14/2025, 11/6/2024 et al.

Plan of Correction ***Directed [redacted] - 07/22/2025)***

1. The Lorazepam and Morphine for Resident #9 on 3/24/25 at 12am were documented as held and nursing notes indicated it was held due to staff feeling like it gave the resident an adverse effect. It is not documented whether or not staff notified the provider to address the resident's observed reaction to the medication to evaluate if a change was needed. Resident #10 no longer resides at the facility. Resident #9's weight will be obtained and physician will be notified by director of wellness or designee by 7/25/2025.
2. A medication record audit for all MARs in June 2025 was completed on July 10, 2025 by the administrator to ensure any medications not given were documented and reported appropriately.
3. Re-education will be provided to all nursing staff (med techs and direct care staff) on 7/23/25 by the administrator and resident care coordinator to ensure staff are aware of proper reporting to PCPs when medication is held or not given. Also, regarding requirement for re-attempts during medication administration, obtaining vitals, providing care, etc and that documentation must be made of re-attempts made. Staff also to be re-educated that it is never acceptable to not give a medication because it is unavailable or a supply is not available, but that it must be reported to nurse management or administration, the pharmacy, physician, or family and documented appropriately so that the proper supply can be obtained for proper administration. Nurse management will be educated by administrator by August 15, 2025 on how to order supplies through online portal and will order supplies monthly and as needed to ensure adequate supplies.
4. An MAR audit will be conducted monthly times three months beginning August 5, 2025 by the administrator or designee to ensure ongoing compliance with 2600.188b. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

(Directed)
In addition to the above plan of correction:

- *Nurse management will be educated by administrator no later than 8/5/25 on how to order supplies through online portal and will order supplies monthly and as needed to ensure adequate supplies.*
- *Resident #9's weight will be obtained and physician will be notified by director of wellness or designee by 7/25/2025. The Administrator or designee will audit resident #9's documentation monthly, beginning no later than 8/1/25 to ensure weights are being obtained per the physician's order.*
- *An MAR audit will be conducted monthly times three months beginning August 5, 2025 by the administrator or designee to ensure ongoing compliance to administer medications and treatments per the physician's orders.*
- *Documentation of education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *08/05/2025*

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

188b - Medication Error Reporting

25. Requirements

2600.

188b - Medication Error Reporting *(continued)*

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #9 is prescribed Lorazepam 0.25mL by mouth every 6 hours routine and Morphine 0.25ML by mouth every 4 hours around the clock. These medications were not administered to resident #9 on 3/24/25 at 12:00 AM. The resident's Lorazepam was also not administered on 4/19/25 at 12:00 AM. These medication errors were not reported to the prescriber.

Resident #9 is prescribed Lorazepam 0.25mL by mouth every 6 hours routine. This medication was not administered on 6/8/25 at 11:43 AM, 6/7/25 at 6:32 AM, 6/5/25 at 12:24 PM, or 6/3/25 at 11:38 AM. These medication errors were not reported to the prescriber.

Plan of Correction ***Accept [redacted] - 07/22/2025)***

1. The Lorazepam and Morphine for Resident #9 on 3/24/25 at 12am were documented as held and nursing notes indicated it was held due to staff feeling like it gave the resident an adverse effect. It is not documented whether or not staff notified the provider to address the resident's observed reaction to the medication to evaluate if a change was needed.
2. A medication record audit for all MARs in June 2025 was completed on July 10, 2025 by the administrator to ensure any medications not given were documented and reported appropriately.
3. Re-education will be provided to all nursing staff on 7/23/25 by the administrator and resident care coordinator to ensure staff are aware of proper reporting when medication is held or not given to prescribers and proper reporting of medication errors.
4. An MAR audit will be conducted monthly times three months beginning in August 5, 2025 by the administrator or designee to ensure ongoing compliance with 2600.188b. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/05/2025*

Implemented [redacted] 09/09/2025)

190c - Record of Training

26. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person C's annual practicum did not include if the staff was requalified, student signature and date or the trainer signature and date.

Plan of Correction ***Accept [redacted] - 07/22/2025)***

1. Upon identifying the documentation error in staff person c's annual practicum on 6/10/2025, the Resident Care Coordinator, who is the train-the-trainer, immediately re-observed the staff person administering medication and

190c - Record of Training (continued)

completed the proper documentation.
2. An audit was completed of all med tech records by the resident care coordinator with no further issues noted on 6/11/2025.
3. Re-education was provided to the resident care coordinator by the administrator on 6/13/2025 regarding 2600.190c.
4. An audit of med tech records will be conducted monthly for three months beginning July 25, 2025 by the resident care coordinator or designee to ensure compliance with 2600.190c. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

Implemented [redacted] - 09/09/2025)

225c - Additional Assessment

28. Requirements

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

Description of Violation

Resident #4's current assessment, dated [redacted]/24, indicated the resident has some memory decline with time, place and person. However, the resident's assessment was never updated to reflect the resident's behavior of wandering into other residents bedrooms and refusing to leave.

Resident #9's current assessment, dated [redacted]/24, indicated the resident is independent in eating and drinking, requires some physical assistance with transferring in/out of bed/chair, some physical assistance when ambulating, is independent with turning and repositioning in bed/chair and has no problem with agitation. However, resident #9 requires assistance with all meals as [redacted] cannot get the food from [redacted] plate to [redacted] mouth and uses [redacted] fingers to feed [redacted]. The resident experiences difficulty when walking at times and requires one-person physical assistance to transfer from the bed to a recliner. Resident #9 is often observed positioned sideways in bed or in [redacted] recliner, sliding to the floor, and requires physical assistance with repositioning to sit/lie correctly and safely. The resident had documented falls to the floor on 1/28/25, 2/1/25, 2/6/25, 2/28/25, 3/28/25, 5/4/25, 5/5/25, 5/12/25, 5/17/25, 5/23/25. Resident #9 also receives Lorazepam every 6 hours for agitation. The resident's assessment was never updated to reflect these changes.

Plan of Correction ***Accept [redacted] - 07/22/2025)***

1. The affected RASP's of resident #4 and resident #9 were reviewed and updated. A new RASP for Resident #9 was completed on 6/16/2025 by [redacted]. Resident #4's RASP was updated with changes on 7/13/2025 by administrator.
2. No other RASPs were identified as being out of compliance. The Director of Wellness put in place a weekly meeting beginning 6/17/2025 with each hospice company and home health agency utilized to ensure all resident updates/changes are discussed and communicated timely so that RASPS can be updated by Director of Wellness or designee as quickly as possible for best resident care outcomes.
3. Re-education provided to Director of Wellness and Resident Care Coordinator by administrator regarding 2600.225c on 6/13/2025.

225c - Additional Assessment (continued)

4. An audit of nursing notes will be completed weekly times four weeks beginning 7/7/2025, and then monthly times two months beginning August 2025 by administrator or designee to ensure residents documented changes are updated in RASPs by Director of Wellness or designee in a timely manner if needed. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/01/2025*

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

231c - Preadmission Screening

29. 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 #4 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/24. The resident's written cognitive preadmission screening was completed on [redacted]/24.

Plan of Correction ***Accept [redacted] - 07/22/2025)***

1. The cognitive portion of the pre-admission screening was incorrectly dated as [redacted]/24. The documentation error occurred more than one year ago.
2. All current cognitive screenings were audited by the administrator on 7/8/2025 to ensure dating accuracy per 2600.231c.
3. Re-education provided to sales/marketing director on 7/11/2025 to ensure compliance with future admissions regarding 2600.231c.
4. An audit of new admissions will be completed monthly for three months beginning August 5, 2025 by the administrator or designee to monitor ongoing compliance with 2600.231c. The results of these audits will be kept by the administrator and used during Quality Assurance/Improvement meetings for review and recommendations.

Licensee's Proposed Overall Completion Date: *08/05/2025*

Implemented [redacted] - 09/09/2025)