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

September 8, 2025

[redacted] PRESIDENT
GAHC3 BOYERTOWN PA ALF TRS SUB LLC
[redacted]

RE: CHESTNUT KNOLL
120 WEST FIFTH STREET
BOYERTOWN, PA, 19512
LICENSE/COC#: 22613

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/12/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CHESTNUT KNOLL* **License #**: *22613* **License Expiration**: *06/30/2026*

Address: *120 WEST FIFTH STREET, BOYERTOWN, PA 19512*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *GAHC3 BOYERTOWN PA ALF TRS SUB LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *11/10/1999* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *154* **Waking Staff**: *116*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *06/12/2025*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *119* **Residents Served**: *101*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *52* **Residents Served**: *50*

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *101*

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

Have Mobility Need: *53* **Have Physical Disability**: *0*

Inspections / Reviews

06/12/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/19/2025*

Inspections / Reviews *(continued)*

07/22/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/31/2025*

09/08/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2025*

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

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 the main floor's hallway by the wellness office, at 10:06 a.m., the laptop located on the medication cart was unlocked, unattended, and accessible to residents' records.

Plan of Correction ***Accept ([redacted] - 07/18/2025)***

Immediate Corrective Action: Staff were alerted during the inspection by the licensing representative that laptop was accessible and the staff member locked the computer screen immediately during the inspection on June 12, 2025.
Additional Corrective Action: Staff were educated by the Executive Director on June 20, 2025 (see attachment 1) regarding the HIPAA violation discovered during inspection and reviewed different ways that HIPPA information could potentially be accessed so that they can avoid any further incidents. Monthly Walk through's will be conducted by Department Managers, starting by July 31, 2025 in all areas in the community to look for any HIPPA concerns and ensure that Computer screens are locked.
Ongoing Quality Assurance Actions: Monthly Walk throughs will be documented (See audit 1) and reviewed during the quarterly Quality Assurance meetings starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented ([redacted] - 09/08/2025)

18 - Compliance With Laws

2. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The batteries for the carbon monoxide monitor located outside the Bistro Kitchenette area were not labeled with the date the batteries were installed as required by the Care Facility Carbon Monoxide Alarms Standards Act. Also, the batteries for the carbon monoxide monitor located outside the personal care kitchen were not labeled with the date the batteries were installed.

Plan of Correction ***Accept ([redacted] - 07/18/2025)***

Immediate Corrective Action: Batteries were replaced and dated with a sticker on the CO2 detector by the Maintenance Director on June 13, 2025 to reflect the date the batteries were changed. (see Attachment 2)
Additional Corrective Actions: Staff that are in charge of changing the batteries were educated by the Executive Director on the need to place the sticker with the date of battery replacement on June 20, 2025 (see attachment 1).
Monthly Walk throughs will be completed by Maintenance Director starting by July 31, 2025 to include checking to ensure that CO2 detectors have a sticker with a date when the batteries were replaced (see Audit 1).
Ongoing Quality Assurance Actions: Monthly Walk throughs will be documented on a form and reviewed Monthly starting by July 31, 2025 by the Executive Director and reviewed during the quarterly Quality Assurance meeting starting by October 31, 2025 to ensure compliance.

18 - Compliance With Laws (continued)

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

51 - Criminal Background Check

3. Requirements

2600.

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

Description of Violation

Staff Person A, who was hired , did not have a Pennsylvania State Police Criminal Background Check requested until

Plan of Correction ***Accept (- 07/18/2025)***

Immediate Corrective Action: We had a new Business Office Director that started on and missed requesting the background check prior to start date. A note was placed in the employee file stating that this error was discovered during the inspection on June 12, 2025.

Additional Corrective Action: All staff files were reviewed by the Business Office Director on June 13, 2025 to ensure that all Background checks were requested prior to start, one more staff was found to have a background check requested after the start date and a note was placed in this employee file to document that the error was discovered on June 13, 2025 when an audit of employee files was completed by the Business Office Director due to finding an error in another staff file on June 12, 2025 during annual inspection.. The Business Office Director was educated by the Executive Director on June 13, 2025 on the need for a background check to be requested prior to start date, see attached (attachment 3). A monthly audit will be completed on 50% of new hires by the Business Office Manager starting by July 31, 2025 to ensure that all new hires have background checks requested before their start date (see Audit 2).

Ongoing Quality Assurance Actions: Monthly audits will be reviewed at the Quarterly QA meetings by the Interdisciplinary team starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

65f - Training Topics

4. Requirements

2600.

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

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Staff person B hired did not receive training in Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during the training year 2024.

Plan of Correction ***Accept (- 07/18/2025)***

Immediate Corrective Action: Staff member B left in and returned in missed the state required training for Meeting the needs of residents as described in the preadmission screening form,

65f - Training Topics (continued)

assessment tool, and medical evaluation and support plan. The training was reviewed and completed by the Business Office Director with staff member B on June 23, 2025 and will be repeated in 2025 to ensure compliance in 2025 (see attachment 4).
Additional Corrective Actions: An audit of all rehires in 2024 was completed on June 13, 2025 by the Business Office Director and there were no further rehires that had missing trainings. The Business Office Director was educated on the annual staff training requirements by the Executive Director on June 13, 2025 (see attachment 3). All rehires will be reviewed monthly starting by July 31, 2025 by the Business Office Director to ensure that all required trainings are completed annually (see audit 2).
Ongoing Quality Assurance Actions: Monthly audits will be reviewed at the Quarterly QA meetings by the Interdisciplinary team starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

65g - Annual Training Content

5. 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.

Description of Violation

Staff Persons B hired , C hired , D hired , E hired F hired and G hired did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year 2024.

Plan of Correction ***Accept (- 07/18/2025)***

Immediate Corrective Action: Staff were educated on Fire evacuation routes specific to Chestnut Knoll on Relias but failed to meet the requirement to complete it with a fire safety expert in person. A note has been placed in their employee file that explains that the in person training was missed in 2024 and was corrected on June 20, 2025 for the 2024 training year.
Additional Corrective Action: Staff members A, B, D, E, F, G were educated on the Fire safety by Executive Director who has been trained by a fire safety expert on June 20, 2025, (see attachment 1 and Executive Director's certificate showing training by a fire safety expert). Staff member C resigned employment effective
Ongoing Quality Assurance Actions: Fire training will be held in person every other month starting in September 2025 for current staff and The Business Office Director will schedule staff to attend in person and will monitor to ensure that all staff participate as part of the employment requirements. Staff training plan will be reviewed at the Quarterly QA meetings by the Interdisciplinary Team starting by October 31, 2025.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

82c - Locking Poisonous Materials

6. 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

At approximately 9:25 a.m. a bottle of hand sanitizer with a manufacturer's label indicating "call poison control if swallowed" was unlocked, unattended, and accessible to residents of the secure dementia unit. All the residents of the secure dementia care unit have been assessed as incapable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 07/18/2025)***

Immediate Corrective Action: The hand sanitizer was removed immediately during inspection on June 12, 2025 by a staff member and the same staff member checked all the lockable cabinets in the Memory Care neighborhood at that time to ensure that there were no other unlocked poisonous materials.
Additional Corrective Actions: Staff were all educated by the Executive Director on June 20, 2025 on the need to ensure that all poisonous materials are kept locked in memory care and for any resident not deemed safe to avoid poisonous materials. Care staff have been educated by the Executive Director on June 20, 2025 to check the cabinets in each memory care dining room after each meal to ensure they are locked (see attachment 1). Weekly audits will be done in each dining room by the Memory Care Director to ensure that the cabinets are being locked starting by July 31, 2025 (see Audit 3).
Ongoing Quality Assurance Actions: Monthly audits will be reviewed at the Quarterly QA meetings by the Interdisciplinary team starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

85d - Trash Receptacles

7. 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

At approximately 9:28 a.m. there was a full, partially uncovered, unattended trash can in the" yellow" bistro. Also, at approximately 9:35 a.m. there was a full, partially uncovered, unattended trash can in the "blue" kitchenette.

Plan of Correction ***Accept (- 07/18/2025)***

Immediate Corrective Action: The trash can lids were replaced by the Maintenance Director the same day as inspection June 12, 2025 (see Attachment 5).
Additional Corrective Actions: Staff were educated on June 20, 2025 by the Executive Director to notify maintenance if any trash can lids break so that they can be replaced as soon as possible (see attachment 1). Weekly audits will be completed by the Maintenance Director starting by July 31, 2025 to ensure that all trash can lids are intact (see Audit 1).
Ongoing Quality Assurance Actions: Monthly audits will be reviewed at the Quarterly QA meetings by the Interdisciplinary team starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

103g - Storing Food

8. Requirements

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

Description of Violation

The freezer in the blue kitchen had three bowls of vanilla ice cream that were opened and unsealed.

Plan of Correction ***Accept (- 07/18/2025)***

Immediate Corrective Actions: Staff disposed of the uncovered, undated ice cream immediately upon discovery on June 12, 2025.
Additional Corrective Actions: Staff were educated by the Executive Director on June 20, 2025 on the importance of ensuring that all items in the refrigerators are covered and have an expiration or open date on them (see attachment 1). Weekly audits will be completed in the refrigerators by the Memory Care Director starting by July 31, 2025 to verify that all items have an expiration date or open date and are appropriately covered (see Audit 3).
Ongoing Quality Assurance Actions: Weekly audits will be reviewed at the Quarterly QA meetings by the Interdisciplinary team starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

121a - Unobstructed Egress

9. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At approximately 9:54 a.m. the exit door located in the personal care area dining room required excessive force to open due to the door sticking to the bottom frame.

Plan of Correction ***Accept (- 07/18/2025)***

Immediate Corrective Action: Maintenance Director inspected the doors on June 25, 2025 to determine that the reason the door was not opening appropriately was due to the weather stripping overlapping (see Attachment 6).
Additional Corrective Actions: The Maintenance Director did check all doors marked as exits on June 13, 2025 to ensure that there were no other doors that had difficulty opening and found no other doors to be difficult to open. Maintenance Director removed the weather stripping on one side and moved it back a ¼ inch to ensure that the weather stripping does not rub and cause the door to difficult to open (see attachment 6). Exit doors will be checked monthly starting by July 31, 2025 by the Maintenance Director to ensure that all exit doors are able to open freely (see Audit 1).
Ongoing Quality Assurance Actions: Monthly checks will be reviewed at the Quarterly QA meetings by the Interdisciplinary team starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

124 - Notice to Fire Department

10. Requirements

2600.

124 - Notice to Fire Department *(continued)*

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have the correct information on the written notification to the local fire department. The letter incorrectly indicates the resident capacity as 111. The facility has a licensed capacity of 119.

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

Immediate Corrective Action: There was a letter sent to the Fire Department on September 1, 2006, to indicate that the capacity in our Memory Care Neighborhood increased from 44 to 52, however it did not indicate that the total capacity increased from 111 to 119. The Executive Director spoke with the , Boyertown Fire Chief on June 23, 2025, during the annual fire inspection to make aware that the total capacity of Chestnut Knoll increased in 2006 from 111 to 119 and had sign a letter indicating acknowledgement (see Attachment 18).
Ongoing Quality Assurance Action: Changes in licensed capacity will be reviewed Quarterly with the Interdisciplinary team starting by October 31, 2025 and if any changes are approved by BHSL, we will notify the Fire Department as required by regulation.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

125a - Combustible Storage

11. Requirements

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

Description of Violation

At approximately 9:55 a.m. a collection of lint was observed in the mulch around the exterior dryer vents. The lint was blowing through the netted bags covering the exterior dryer vents.

Plan of Correction ***Accept (- 07/18/2025)***

Immediate Corrective Actions: The Maintenance Director replaced the lint bags on Friday June 13, 2025.
Additional Corrective Actions: The Maintenance Director will increase the frequency of changing the lint bags on the outside lint traps to twice a week on a Friday and Tuesday starting July 1, 2025. This will be monitored with each lint bag change and monitored Monthly by the Maintenance Director starting by July 31, 2025, if needed, we will increase the frequency (see Audit 1).
Ongoing Quality Assurance Actions: The interdisciplinary team will review the findings of the twice a week monitoring of the lint bags at the Quarterly QA meetings starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 09/08/2025)

131f - Fire Extinguisher Inspection

12. Requirements

2600.
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.

131f - Fire Extinguisher Inspection *(continued)*

Description of Violation

The fire extinguishers in the home's top floor have not been inspected by a fire safety expert since May 2024.

Plan of Correction ***Accept (- 07/18/2025)***

Immediate Corrective Actions: The company that inspects our fire extinguishers was here on June 19, 2025, to complete the annual inspection of the fire extinguishers. They did provide a statement that in 2024 they did inspect all fire extinguishers in the building during the month of June but inadvertently marked the wrong month on the extinguishers on the 300 level (see attachment 7).
Additional Corrective Actions: Maintenance Director did verify that all extinguishes were marked as June 2025 after the June 19, 2025, inspection. During the monthly fire extinguisher inspection completed by the maintenance team, starting by July 31, 2025 Maintenance Director will verify that all tags are marked appropriately and are not overdue, and the annual inspection will then occur in June 2026 for all extinguishers (see Audit 1).
Ongoing Quality Assurance Actions: The monthly inspection of fire extinguishers will be reviewed during the Quarterly QA meetings with the interdisciplinary team starting by October 31, 2025 for compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

144c1 - Smoking Area Guidelines

13. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's smoking policy indicates the following: "This Personal Care Facility takes pride in the fact that it is a non-smoking community. Smoking inside or outside the building is strictly prohibited." At approximately 10:22 a.m. staff were observed smoking and vaping in an area outside the ground floor exit that had a sign posted indicating "No Vaping or Smoking of Any Kind Allowed".

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

Immediate Corrective Action: The "No Smoking or Vaping" signs were removed from the staff smoking area on July 7, 2025.
Additional Corrective Action: The Maintenance Director ordered a "designated smoking area" sign and hung it at the staff smoking area on July 7, 2025 (see attachment 9). The employee smoking policy has been updated by the Executive Director on June 30, 2025 to reflect that staff are permitted to smoke on the premises in the designated area and how to respond to a fire in the designated smoking area, if necessary (attachment 10).
Ongoing Quality Assurance Actions: The smoking area will be checked during the monthly walk through by the Maintenance Director starting by July 31, 2025 to ensure that the designated smoking sign is posted appropriately (see Audit 1). The monthly checks will be reviewed at the Quarterly QA meetings staring by October 31, 2025.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

185a - Implement Storage Procedures

14. Requirements

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

Description of Violation

Resident #1 has orders for Bisacodyl 10mg suppository, one suppository daily as needed and Tylenol 650mg suppository, one suppository every 4 hours as needed. These medications were not available in the medication cart to be administered if needed.

Resident #3's glucometer reading on 6/8/25 at 8:41 a.m. was 299. The glucometer reading was incorrectly recorded as 200 on the Medication Administration Record.

Repeat Violation 7/30/24

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

Immediate Corrective Action: The PRN medications for Resident 1 and Resident 3 that were missing were re-ordered on June 12, 2025, and were received later the same evening (see attachment 11).
Additional Corrective Actions: Current PRN medication orders were reviewed by the Resident Care Director on June 13, 2025 to ensure that all PRN orders have medications here and available, any missing PRN medications were ordered and received. Staff education was completed by the Executive Director on June 20, 2025 with med techs to review the errors found and reminder that they must verify BS readings before recording them in the MAR as well as the need to ensure that if we have an order, we must have the medication available (see Attachment 12). Starting by July 31, 2025, the Resident Care Director will complete monthly Medication cart audits to ensure that all PRN medications are available (see Audit 4) The Resident Care Director will complete weekly audits starting the week of July 21, 2025, on 10% of orders that have parameters to ensure that the Blood Sugars are recorded properly (see Audit 5).
Ongoing Quality Assurance Actions: Monthly and weekly audits will be reviewed at the Quarterly QA meeting with the interdisciplinary team starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 09/08/2025)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

Resident #4 has an order for Midodrine 5 mg, take 1 tab orally by mouth twice daily for hypotension, HOLD for Systolic Blood Pressure greater than 120. On 6/2/25 at 6:03 p.m. the resident had a blood pressure of 159/72; the medication was administered. On 6/6/25 at 7:00 p.m. the resident had a blood pressure of 136/66; the medication was administered.

Resident #5 has an order for Carvedilol 3.125 mg, take 1 tab orally twice daily for hypertension, HOLD for Systolic Blood Pressures less than 110. On 6/3/25 at 8:00 p.m. the resident's blood pressure was 109/72, the medication was administered.

187d - Follow Prescriber's Orders (continued)

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

Immediate Corrective Actions: A reportable incident was completed by the Executive Director on June 12, 2025, and sent to BHSL to report the medication errors that were found during the inspection (see attachment 13). Resident 4 and Resident 5 providers and families were notified of the medication errors.
Additional Corrective Actions: Staff education was provided to Med Techs by the Executive Director on June 20, 2025 to review that physician orders must be followed and to pay special attention to orders that have parameters to ensure that we are administering medications correctly (see attachment 12). The Resident Care Director will complete weekly audits starting the week of July 21, 2025, on 10% of orders that have parameters to ensure that staff are administering medications as prescribed and holding medications as order by the prescriber (see Audit 5).
Ongoing Quality Assurance Actions: Monthly and weekly audits will be reviewed at the Quarterly QA meeting with the interdisciplinary team starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 09/08/2025)

224a - Preadmission Screen Form

16. Requirements

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

Description of Violation

Resident #6's preadmission screening form, dated , does not include a determination that the needs of the resident can be met by the services provided by the home. The preadmission screening form did not have the level of supervision needs, mobility needs, ability to self-administer medications, and if the resident is able to safely use and avoid poisonous materials as completed.

Resident #2 was admitted to the home on Resident #2's preadmission screening form was not dated when completed and did not include the resident's mobility needs or ability to self-administer medications.

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

Immediate Corrective Actions: Resident Care Director completed the date, Mobility status and medication administration sections of the Prescreen for Resident # 2 and 6 (see attachment 14) on June 14, 2025. These items were recorded in a different area of the resident's chart in Tabula but were missed when completing the state form.
Additional Corrective Action: Resident Care Director reviewed all Prescreen forms on June 14, 2025 to ensure that all required sections of the state form were completed. Chart Audits will be completed on 5% of resident charts monthly starting by July 31, 2025 to include DME's, Prescreens and RASPs by the Resident Care Director, Memory Care Director and Executive Director (see attachment 15).
Ongoing Quality Assurance Actions: Monthly chart audits will be reviewed at the Quarterly QA meetings by the Interdisciplinary team starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/15/2025)

226a - Mobility Assessment

17. Requirements

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident #6's assessment, dated [redacted] does not include an assessment of the resident's mobility needs.

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

Immediate Corrective Action: Resident 6's RASP was corrected by the Resident Care Director on June 13, 2025 to include the checkmark on the Mobility Assessment that was inadvertently missed (see attachment 16).
Additional Corrective Actions: RASPs were reviewed by the Resident Care Director and Memory Care Director on June 14, and 16, 2025 to verify that there were no other residents that had RASPs with missing information. Chart Audits will be completed on 5% of resident charts monthly starting by July 31, 2025 to include DME's, Prescreens and RASPs by the Resident Care Director, Memory Care Director and Executive Director (see attachment 15).
Ongoing Quality Assurance Actions: Monthly chart audits will be reviewed at the Quarterly QA meetings by the Interdisciplinary team starting by October 31, 2025 to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented ([redacted] - 08/15/2025)

233c - Key-Locking Devices

18. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the exit door leading from the Secure Dementia Care Unit (SDCU). The code to unlock the door using the keypad was posted on a small sticker on the side of the red alarm locking box affixed to the door.

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

Immediate Corrective Action: This code has been posted in its current position for the last 20 years and we do feel that it is in a conspicuous area. Code was reposted on the door frame to Memory Care by the Executive Director on July 2, 2025 in a more conspicuous area as per the recommendation during inspection (see Attachment 17)
Additional Corrective Actions: The code location and legibility will be monitored by the Memory Care Director on a weekly basis starting by July 31, 2025 (see Audit 3).
Ongoing Quality Assurance Actions: We will review the location to ensure that it remains appropriate and legible at the Quarterly QA meetings starting by October 31, 2025.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented ([redacted] - 08/15/2025)