pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **DUNLEVY MANOR LIVING LLC**
LEGAL ENTITY

To operate **DUNLEVY MANOR LIVING**
NAME OF FACILITY OR AGENCY

Located at **2218 PA-88, DUNLEVY, PA 15432**
(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 **24**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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 23, 2025** until **September 23, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **455970**

ISSUING OFFICER

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 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

EMAILING DATE: SEPTEMBER 23, 2025

[redacted]
Dunlevy Manor Living LLC
2218 PA-88
Dunlevy, Pennsylvania 15432

RE: Dunlevy Manor Living
2218 PA-88
Dunlevy, Pennsylvania 15432
License #: 45597

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on June 25, 2025 and August 21, 2025, and the corrections you have made after our inspection, we have found the above facility to be in compliance with Title 55, PA Code, Chapter 2600. Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
License
Licensing Inspection Summary

Facility Information

Name: *DUNLEVY MANOR LIVING* **License #**: *45597* **License Expiration**: *09/21/2025*

Address: *2218 PA-88, DUNLEVY, PA 15432*

County: *WASHINGTON* **Region**: *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *DUNLEVY MANOR LIVING LLC*

Address: *2218 PA-88, DUNLEVY, PA, 15432*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/03/2024* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *14* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *06/25/2025*

Inspection Dates and Department Representative

06/25/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *9*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *9*

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

Have Mobility Need: *5* **Have Physical Disability**: *1*

Inspections / Reviews

06/25/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/11/2025*

07/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/30/2025*

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

Inspections / Reviews *(continued)*

07/24/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/30/2025*

08/26/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/30/2025*

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

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #1's contract, dated [redacted]/24, was not signed by the resident and did not indicate the resident was unable or unwilling to sign.

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

Description of the deficiency: It was identified that resident #1's admission contract was not signed by the resident or their legal representative upon admission. This is a violation regulatory requirements and facility policy.

Immediate corrective action taken: The unsigned contract was immediately presented to the resident for review and signature.
Staff documented the date the contract was signed and placed a copy in the resident's file on 6/26/25.

Measures to prevent recurrence: A checklist has been added to the admission packet to confirm that all required signatures are obtained before finalizing the admission process.
The administrator or designee will be responsible for ensuring the contract is signed prior to move-in unless an emergency admission occurs, in which case it must be signed within 24 hours.

Staff training: All staff involved in the admissions process will receive in -service training on the importance of obtaining all required signatures on contracts before or immediately upon admission. Training will be held on 7/23/25 by the administrator. Documentation will be kept.
Training will include documentation standards and legal implications of unsigned contracts. Documentation will be kept.

Monitoring and quality assurance: The administrator or designee will audit all new admissions weekly for the next 60 days to ensure that contracts are fully signed. Findings will be documented, and any discrepancies will be corrected immediately. Ongoing audits will be conducted monthly as part of the facility's QA program.

Responsible party: [redacted]. will be responsible for ensuring the implementation and ongoing compliance with this plan.

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

Implemented [redacted] - 08/26/2025)

63a - First Aid/CPR Training

2. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

63a - First Aid/CPR Training *(continued)*

Description of Violation

On 6/15/25 there were 9 residents present in the home, however, direct care staff person A and direct care staff person B were the only aides in the home and neither staff person was trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) from 7:00 p.m. until 12:00 a.m.

On 6/16/25 there were 9 residents present in the home, however, direct care staff person A and direct care staff person B were the only aides in the home and neither staff person was trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) from 12:01 a.m. until 7:00 a.m.

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

Deficiency: No CPR/First Aid certified staff member was scheduled during [date/time of incident].

Plan of Correction
Immediate Corrective Action Taken
As soon as the deficiency was identified, [Facility Name] immediately scheduled a CPR/First Aid certified staff member to be on duty. A review of the upcoming schedules was conducted to ensure coverage was restored without delay.

Identification of Other Residents/Clients Affected
All residents/clients present during the uncovered shift were identified. A full review confirmed that no adverse events occurred during the period in which no certified staff was scheduled.

Measures to Prevent Recurrence

A new scheduling policy has been implemented to require at least one CPR/First Aid certified staff member per shift.

A certification tracker spreadsheet/system was created to monitor certification status and expiration dates for all staff.

Only staff with current CPR/First Aid certification will be eligible to serve as the designated shift lead.

Staff Training

All supervisors and schedulers were trained on the new policy and procedure for ensuring certified staff coverage.

A refresher course on CPR/First Aid certification requirements was provided to all staff by 08/01/25.
Monitoring and Quality Assurance

The Administrator or designee will audit the schedule weekly for 90 days to ensure compliance with the policy.

Any identified scheduling gaps will be documented and corrected before shifts begin.

After 90 days, monitoring will continue monthly for at least one year.

Responsible party: [redacted]. will be responsible for ensuring

63a - First Aid/CPR Training (continued)

the implementation and ongoing compliance with this plan.

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

Implemented [redacted] - 08/26/2025)

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

At approximately 12:15 p.m. there was a pervasive odor of urine emanating from resident room [redacted] belonging to resident #2.

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

Deficiency: Unsanitary conditions noted—urine odor detected in a resident's room, indicating inadequate cleaning and hygiene practices.

Plan of Correction
Immediate Corrective Action Taken
Upon discovery, the room was immediately cleaned and sanitized. Soiled linens and clothing were removed and laundered. The resident received personal hygiene care. Air purification methods (ventilation, odor-neutralizing spray) were used to eliminate residual odor.

Identification of Other Residents Affected
A full inspection of all resident rooms was conducted to identify similar concerns. No additional odors or sanitation issues were noted. All rooms were cleaned as a precaution.

Measures to Prevent Recurrence

A daily housekeeping checklist has been implemented for each resident room, with a focus on identifying and addressing odors, spills, and soiling.

Care staff are now required to report any signs of incontinence or unclean conditions to housekeeping and nursing staff immediately.

Incontinence care protocols have been reviewed and reinforced with staff to ensure timely toileting and hygiene.

Staff Training

All direct care and housekeeping staff will received in-service training on July 07/23/25 covering:

Proper cleaning protocols

85a - Sanitary Conditions (continued)

Odor control techniques

Recognizing and reporting hygiene issues

Documentation of training is maintained in staff files.

Monitoring and Quality Assurance

Supervisors will perform unannounced room inspections 3x weekly for 60 days to ensure cleanliness and odor control.

The Administrator or designee will conduct random checks and review cleanliness logs weekly.

Ongoing staff performance will be reviewed during monthly QA meetings.

Responsible party: [redacted] *. will be responsible for ensuring the implementation and ongoing compliance with this plan.*

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

Implemented [redacted] ***- 08/26/2025)***

89b - Hot Water Temperature

4. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

At approximately 11:58 a.m., the water temperature at the sink in the Jack and Jill half bathroom between resident room #12 belonging to resident #3 and the unoccupied resident room #11 measured 136.8 degrees Fahrenheit. At approximately 5:18 p.m. the water temperature was measured again and indicated 114.4 degrees Fahrenheit.

At approximately 12:07 p.m., the water temperature at the sink in the Jack and Jill full bathroom between resident room #10 belonging to resident #4 and the unoccupied resident room #9 measured 129.7 degrees Fahrenheit. At approximately 5:20 p.m. the water temperature was measured again and indicated 112.1 degrees Fahrenheit.

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

Deficiency: Hot water temperatures measured above 120°F, creating a potential safety hazard for residents/clients.

Plan of Correction
Immediate Corrective Action Taken
Upon identification of the issue, maintenance staff immediately adjusted the water heater thermostat to ensure the maximum temperature does not exceed 120°F. Water temperatures at all fixtures accessible to residents were

89b - Hot Water Temperature (continued)

re-checked to confirm compliance.

Identification of Other Residents/Clients Affected
All rooms and water sources were checked to assess risk. No injuries or incidents related to hot water were reported. Preventative checks were conducted facility-wide to ensure no other hot water sources exceeded safe limits.

Measures to Prevent Recurrence

A temperature monitoring log has been implemented. Water temperature will be checked at multiple outlets (sinks, showers, tubs) at least weekly.

Maintenance staff have been instructed to document any adjustments made to water heater settings.

Staff Training

Maintenance and direct care staff received training on 07/23/25 regarding:

Safe water temperature standards

How to check and log water temperatures

How to recognize signs of water temperature risks for clients

Staff were also instructed to report any unusually hot water immediately.

Monitoring and Quality Assurance

Administrator or designee will audit water temperature logs weekly for 90 days, then monthly.

Random spot-checks of water temperatures will be conducted by supervisory staff and documented.

Any reading above 120°F will result in immediate corrective action and rechecking.

Responsible party: [redacted] *. will be responsible for ensuring the implementation and ongoing compliance with this plan.*

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

Implemented [redacted] ***- 08/26/2025)***

101o - Walls, Floors, Ceilings

5. Requirements

2600.

101o - Walls, Floors, Ceilings *(continued)*

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

Description of Violation

At approximately 12:15 p.m. the carpet to the left of the bed and in front of the bedside table in resident room #8 belonging to resident #2 was heavily worn and appeared to be soiled and dark in an area measuring approximately twenty-four inches by eighteen-inches in a circular pattern.

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

Deficiency: Soiled and stained carpet observed in a resident's room, compromising sanitation and resident comfort.

Plan of Correction
Immediate Corrective Action Taken
Upon identification, the affected carpet was professionally cleaned on [insert date]. Furniture was temporarily removed, and the room was ventilated to ensure drying and odor removal. The resident was relocated or supported to remain comfortably during cleaning, as needed.

Identification of Other Residents Affected
A full inspection of all resident rooms and common areas with carpeting was completed. Any additional soiled carpets were identified, and cleaning or replacement was scheduled immediately.

Measures to Prevent Recurrence

A quarterly carpet inspection schedule has been implemented to proactively identify stains, odors, and wear.

All spills and accidents are now reported and logged by staff for immediate follow-up by housekeeping.

Protocols have been reinforced to ensure prompt incontinence clean-up and preventative protection (e.g., underpads, chair mats) where appropriate.

Staff Training

On 07/23/25, housekeeping and care staff will received training on:

Reporting and responding to soiled flooring

Use of appropriate cleaning agents and techniques

Communication procedures between care staff and maintenance/housekeeping

Monitoring and Quality Assurance

Room checks for flooring condition will be conducted weekly by the Housekeeping Supervisor.

Any stains or soiling will be documented in the Maintenance Log, with follow-up actions taken within 24 hours.

Findings and trends will be reviewed monthly in Quality Assurance meetings.

101o - Walls, Floors, Ceilings (continued)

Responsible party: [redacted] *. will be responsible for ensuring the implementation and ongoing compliance with this plan.*

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

Implemented [redacted] ***- 08/26/2025)***

103d - Storing Food Off Floor

6. Requirements

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

Description of Violation

At approximately 11:01 a.m. there was a ten-pound bag of russet potatoes that was approximately one-half full that was found on the floor of the dry storage area to the left of the home's [redacted] *hot water tank.*

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

Deficiency: Improper food storage observed—an approximately half-full 10-pound bag of russet potatoes was stored on the ground near the hot water tank.

Plan of Correction
Immediate Corrective Action Taken
The bag of potatoes was immediately removed and discarded due to potential contamination. The area near the hot water tank was cleaned and sanitized. Staff were reminded on the spot about proper food storage requirements.

Identification of Other Residents/Clients Affected
No direct resident or client impact was identified. All food storage areas were inspected, and no additional improperly stored food was found.

Measures to Prevent Recurrence

A designated dry food storage area was reaffirmed and reorganized to ensure all food items are kept:

Off the ground (minimum 6 inches)

Away from utility systems, including water heaters

In cool, dry, pest-free zones

Signage was posted in storage areas reminding staff of food safety requirements.

Unused or overflow food storage practices were reviewed and corrected.

103d - Storing Food Off Floor (continued)

Staff Training

On 7/23/25 all dietary, housekeeping, and care staff received a refresher training on:

Proper food storage protocols (including safe distances from heat sources)

Sanitation and pest-prevention standards

How and where to report improperly stored items

Monitoring and Quality Assurance

Weekly kitchen and utility room inspections are now conducted by the Housekeeping Supervisor or designee.

Inspection findings are logged and reviewed during monthly QA meetings.

Any food storage violations will result in corrective coaching and documentation.

Responsible party: [redacted], [redacted]. will be responsible for ensuring the implementation and ongoing compliance with this plan.

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

Implemented [redacted] - 08/26/2025)

103f - Refrigerator/Freezer Temps

7. Requirements

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

Description of Violation

At approximately 10:45 a.m. the thermometer in the refrigerator portion of the Frigidaire Refrigerator and Freezer was inoperable and a temperature reading could not be taken. Ancillary staff person C placed a new thermometer in the refrigerator at 10:50 a.m. and at approximately 12:32 p.m. the temperature was checked again and measured thirty-eight degrees Fahrenheit.

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

Deficiency: Food requiring refrigeration must be stored at or below 40°F, and frozen food at or below 0°F. The thermometer in both the refrigerator and freezer was found to be inoperable, preventing verification of proper storage temperatures.

Plan of Correction
Immediate Corrective Action Taken
Upon discovery, the inoperable thermometer was immediately removed and replaced with a functioning, calibrated thermometer on [insert date]. Refrigerator and freezer temperatures were then verified and found to be within the

103f - Refrigerator/Freezer Temps (continued)

required safe ranges (= 40°F for refrigeration and = 0°F for freezer).

Identification of Other Residents/Clients Affected
A review of all perishable and frozen food items was conducted. No spoilage or foodborne illness risks were identified. No residents/clients were affected.

Measures to Prevent Recurrence

All refrigerators and freezers will now be equipped with clearly visible, functioning thermometers.

A daily temperature log has been implemented for all cold storage units.

Any unit found outside of the required temperature range or with a faulty thermometer will be immediately addressed by maintenance and reported to the Administrator or designee.

Staff Training

On 7/23/25, all dietary, housekeeping, and direct care staff were retrained on:

Proper cold food storage temperatures

How to read and record thermometer readings

Steps to take if temperatures fall outside safe ranges or equipment malfunctions

Monitoring and Quality Assurance

Temperature logs will be reviewed weekly by the Administrator or Housekeeping Supervisor for accuracy and compliance.

Monthly audits will be conducted to ensure thermometers are functional and present in all units.

These logs and findings will be reviewed during monthly Quality Assurance meetings.

Responsible party: [redacted]*. will be responsible for ensuring the implementation and ongoing compliance with this plan.*

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

Implemented [redacted] ***- 08/26/2025)***

103g - Storing Food

8. Requirements

103g - Storing Food *(continued)*

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

Description of Violation

At approximately 11:10 a.m. there were two bags of pasta found in the home's dry storage area that were open and sealed, one bag was Barilla brand penne pasta, a ten-pound bag with approximately one-and-one-half pound remaining, and the other bag was a ten-pound unbranded bag of broad egg noodles that contained approximately three-pounds of pasta.

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

Deficiency: Improper food storage observed—two open and unsealed bags of pasta were found in the dry storage area, creating a potential risk of contamination and pest infestation.

Plan of Correction
Immediate Corrective Action Taken
The two open and unsealed bags of pasta were immediately discarded on [insert date] due to contamination risk. All other dry food items in the storage area were inspected, and no further violations were found. The storage area was cleaned and organized.

Identification of Other Residents/Clients Affected
No residents or clients were directly affected. No meals were prepared using the unsealed items. Food inventory and preparation logs were reviewed to confirm safety.

Measures to Prevent Recurrence

A policy was reinforced that all opened dry goods must be stored in sealed, airtight containers labeled with the product name and date of opening.

A sufficient number of food-safe, airtight storage containers have been provided for staff use.

Open food storage areas will now be part of the weekly kitchen inspection checklist.

Staff Training

On 07/23/25, all kitchen and direct care staff were retrained on:

Proper dry food storage practices

Sanitation and pest prevention protocols

Labeling and handling of opened food products

Monitoring and Quality Assurance

The Housekeeping or Dietary Supervisor will inspect the dry storage area weekly to ensure compliance.

103g - Storing Food (continued)

Findings will be documented in the food safety inspection log.

Storage practices will be reviewed during monthly QA meetings, and any non-compliance will be addressed immediately with corrective coaching.

Responsible party: [redacted] *. will be responsible for ensuring the implementation and ongoing compliance with this plan.*

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

Implemented [redacted] ***- 08/26/2025)***

123b - Emergency Procedures Posted

9. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

At approximately 2:33 p.m. the emergency procedures for the home and municipality were in a cabinet behind a closed door in the administrator's office and not posted in a conspicuous and public place in the personal care home.

Plan of Correction ***Accept*** [redacted] ***- 07/24/2025)***

Deficiency: The emergency procedures for the home and municipality were stored in a cabinet behind a closed door in the Administrator's office and not posted in a conspicuous and public place, as required by regulation.

Plan of Correction
Immediate Corrective Action Taken
On 6/25/25, the emergency procedures for the home and municipality were removed from the cabinet and posted in clearly visible locations throughout the home, including:

The main entrance lobby

The staff break area

The central hallway bulletin board
This ensures that staff, residents, and visitors can easily access emergency information at all times.

Identification of Other Residents/Clients Affected
No adverse effects to residents or clients were reported. However, the lack of visibility of emergency procedures could have delayed response in an actual emergency. This risk has been mitigated by immediate posting.

Measures to Prevent Recurrence

A policy update was made to require emergency procedures to be posted at all times in at least two public areas.

123b - Emergency Procedures Posted (continued)

A checklist has been added to the monthly safety audit to ensure postings remain intact, updated, and readable.

Emergency procedures will be reviewed quarterly to ensure accuracy and that postings reflect current contact numbers and evacuation routes.

Staff Training

On 07/23/25, all staff will be retrained on:

The location of emergency procedures

Their role in emergency response

The importance of accessible emergency information

New hire orientation now includes a walkthrough of emergency procedure postings.

Monitoring and Quality Assurance

The Administrator or designee will check emergency procedure postings monthly during facility rounds.

Any missing or damaged postings will be replaced immediately.

A record of all inspections and updates will be maintained in the Safety Binder.

Responsible party: [redacted]. will be responsible for ensuring the implementation and ongoing compliance with this plan.

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

Implemented [redacted] - 08/26/2025)

132e - Fire Drill Sleeping Hours

10. Requirements

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

Description of Violation

The home's most recent sleeping hours fire drill was held on 8/15/24 at 6:00 a.m.

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

Deficiency: A fire drill during sleeping hours is required at least once every six months. The home's most recent drill, conducted on August 15, 2024, at 6:00 a.m., does not meet the regulatory definition of sleeping hours, which typically refers to the time residents are asleep (e.g., between 10:00 p.m. and 6:00 a.m.).

132e - Fire Drill Sleeping Hours (continued)

Plan of Correction
Immediate Corrective Action Taken
Upon realizing the error, the Administrator scheduled and conducted a corrective sleeping hours fire drill on [insert date], between the hours of [insert time, e.g., 2:30 a.m.], to ensure full compliance with the regulation. The drill was documented, and resident safety was maintained throughout.

Identification of Other Residents/Clients Affected
All residents were accounted for and safely participated in the drill. There were no injuries or adverse events. Staff were briefed prior to the drill to minimize disruption and anxiety for residents.

Measures to Prevent Recurrence

The home's fire drill schedule has been updated to clearly designate one sleeping hours drill every six months (between 10:00 p.m. and 6:00 a.m.).

The drill log will now include a checkbox to confirm whether a drill occurred during sleeping hours.

The Emergency Preparedness policy was revised to define acceptable "sleeping hours" in alignment with regulatory expectations.

Staff Training

On 07/23/25, all staff will be retrained on:

Fire drill requirements, including the definition of "sleeping hours"

Proper procedures for conducting nighttime drills with minimal resident disturbance

Documentation standards for emergency drills

Monitoring and Quality Assurance

The Administrator will review and approve the fire drill schedule quarterly to ensure compliance with timing requirements.

Drill reports will be reviewed in monthly safety committee meetings for accuracy and completeness.

Missed or mis-timed drills will be flagged for immediate rescheduling.

Responsible party: [redacted]. will be responsible for ensuring the implementation and ongoing compliance with this plan.

132e - Fire Drill Sleeping Hours *(continued)*

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

Implemented [redacted] - 08/26/2025)

141a 1-10 Medical Evaluation Information

11. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation, dated [redacted]/24, indicated "see attached med list" for medications, however, there was nothing attached to the medical evaluation form.

Resident #3's medical evaluation, dated [redacted]/25, did not include the resident's ability to self-administer medications, that section of the medical evaluation was blank.

Resident #3's medical evaluation, dated [redacted]25, did not document the resident's need for body positioning / movement, that section of the medical evaluation was blank.

The home's medical evaluations were not documented on a form specified by the Department.

REPEAT VIOLATION 11/12/24

Plan of Correction ***Accept [redacted] - 07/24/2025)***

Deficiency: A resident's medical evaluation form was incomplete. It was not completed by a physician, the required medication list was not attached, and the section addressing the resident's movement abilities was left blank.

Plan of Correction
Immediate Corrective Action Taken

The incomplete medical evaluation was returned to the physician for immediate completion on 6/26/25.

A signed and complete evaluation form, including the medication list and the movement section, was received and filed in the resident's chart on [insert date].

141a 1-10 Medical Evaluation Information (continued)

The Administrator conducted a full audit of all current resident medical evaluations to ensure completeness and physician signatures.

Identification of Other Residents Affected
A review of all resident files was conducted. No other incomplete evaluations were found. If any future deficiencies are identified, immediate corrections will be made and documented.

Measures to Prevent Recurrence

A medical evaluation intake checklist has been implemented to ensure all required components (including physician signature, medication list, and all sections such as movement) are complete before accepting or filing the form.

All medical evaluations will now be reviewed by the Administrator or designee upon receipt.

Any incomplete evaluations will be returned to the physician's office within 24 hours for correction.

Staff Training

On 07/23/25, administrative and admissions staff will be retrained on:

Required components of a complete medical evaluation

The review and verification process prior to accepting documentation

How to follow up with physicians for incomplete forms

Monitoring and Quality Assurance

The Administrator or designee will audit 10% of all resident records monthly to verify compliance with medical evaluation documentation standards.

Results will be reviewed during monthly Quality Assurance/Improvement meetings.

Ongoing deficiencies will be addressed through retraining or process adjustments.

Responsible party: [redacted] *. will be responsible for ensuring the implementation and ongoing compliance with this plan.*

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

Implemented ([redacted] - 08/26/2025)

141b1 - Annual Medical Evaluation

12. Requirements

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

Description of Violation

Resident #4's medical evaluation, dated [redacted]25, did not indicate the resident's diagnoses, and only included medical codes. The medical evaluation also indicated "See medication addendum," for medications, however, there was nothing attached to the medical evaluation form. Additionally, resident #4's medical evaluation was not documented on a form specified by the Department.

REPEAT VIOLATION 11/12/24

Plan of Correction ***Accept [redacted] - 07/24/2025)***

Deficiency: A resident's required annual medical evaluation, dated [redacted] 2025, was incomplete. It did not indicate the resident's diagnosis (only medical codes were provided), referenced a "C Medication Addendum" with no document attached, and was not completed on the form specified by the department.

Plan of Correction
Immediate Corrective Action Taken

The incomplete medical evaluation was returned to the resident's physician on [insert date] with a request for full correction and completion using the official Department-specified form.

A corrected evaluation was received on [redacted]/25, including:

Full written diagnoses (not just ICD codes)

A complete and signed medication list/addendum

Completion of the appropriate, department-approved form

The corrected documentation was placed in the resident's medical file.

Identification of Other Residents Affected
A full audit of all resident medical evaluations was completed. No other records were found to be missing diagnosis descriptions, medication lists, or required forms. Any incomplete evaluations discovered during this audit were corrected and updated as necessary.

Measures to Prevent Recurrence

A Medical Evaluation Submission Checklist has been implemented to verify:

Use of the correct Department-approved form

Clear written diagnoses (no codes-only entries)

141b1 - Annual Medical Evaluation (continued)

Inclusion of the medication list or any referenced addenda

Physician signature and completion of all required sections

Staff responsible for admissions and annual evaluation tracking will now verify each medical evaluation against this checklist before filing.

Staff Training

On 07/23/25, all relevant staff (including admissions, medical records, and care coordinators) will be retrained on:

Department requirements for annual medical evaluations

Identifying incomplete documentation

Proper follow-up procedures with physician offices for missing or incomplete forms

Monitoring and Quality Assurance

The Administrator or designee will audit 20% of resident medical evaluations monthly for the next 3 months, and then quarterly thereafter.

Any discrepancies or non-compliance will result in immediate correction and retraining.

Compliance will be reviewed in ongoing Quality Assurance meetings and tracked in documentation logs.

Responsible party: [redacted] *. will be responsible for ensuring the implementation and ongoing compliance with this plan.*

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

Implemented [redacted] ***- 08/26/2025)***

187a - Medication Record

13. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
11. Special precautions, if applicable.

Description of Violation

Resident #1 is prescribed Losartan Potassium tablets 25mg, take 1 tablet by mouth every day, hold if blood pressure less than 100/60. However, on 6/7/25 and 6/9/25, the Losartan Potassium was documented as administered by direct care staff person D, but the systolic and diastolic blood pressure was not documented on resident #1's June 2025

187a - Medication Record (continued)

medication administration record(MAR), those areas were left blank.

Resident #3 is prescribed Amlodipine 5mg tablet, take 1 tablet by mouth every day *Hold for systolic blood pressure less than 100 and HR<50. However, resident #3's June 2025 MAR did not include an area to document the systolic blood pressure or heart rate of the resident.

Resident #3 is prescribed Carvedilol 3.125mg tablet, take 1 tablet by mouth twice a day *Hold for systolic blood pressure less than 100 and HR<50. However, resident #3's June 2025 MAR did not include an area to document the systolic blood pressure or heart rate of the resident at either 9:00 a.m. or 8:00 p.m.

REPEAT VIOLATION 2/19/25, 11/12/24

Plan of Correction ***Accept [redacted] - 07/24/2025)***

Deficiency: Medication administration records must include all required documentation for each resident. A resident's prescribed medication was documented as administered by direct care staff; however, the required blood pressure reading was not recorded, resulting in an incomplete medication record.

Plan of Correction
Immediate Corrective Action Taken

The omission was identified on 6/26/25. The responsible staff member was immediately counseled, and the incident was documented.

The resident's current status was assessed to ensure no adverse effects occurred due to the documentation gap.

Direct care staff were reminded of the requirement to take and document blood pressure before administering medications where vital sign monitoring is indicated.

Identification of Other Residents Affected

A review of all residents receiving medications that require vital sign monitoring (e.g., blood pressure, pulse) was completed.

No additional documentation omissions were found. If any had been discovered, they would have been corrected immediately with proper follow-up.

Measures to Prevent Recurrence

A revised Medication Administration Record (MAR) audit process is now in place to ensure:

Blood pressure (or other vitals) are documented where clinically required

Documentation matches all administration instructions and prescriber orders

A reminder has been added to MAR forms to prompt staff to enter required vitals before recording administration

187a - Medication Record (continued)

of applicable medications.

Staff Training

On 07/23/25, all direct care staff will received retraining on:

Proper medication documentation practices

When vital signs (e.g., blood pressure) are required before administration

How to correct errors and omissions following the home's medication error policy

Staff signed off to confirm understanding and compliance expectations.

Monitoring and Quality Assurance

The Medication Administration Records will be reviewed daily by the Medication Supervisor or designee to ensure completeness.

Weekly audits will be conducted for three months to check for consistent blood pressure documentation where required.

Results will be reviewed during monthly Quality Assurance meetings and corrective coaching provided as needed.

Responsible party [redacted]. will be responsible for ensuring the implementation and ongoing compliance with this plan.

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

Implemented [redacted] - 08/26/2025)

191 - Resident Right to Refuse

14. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

There was no documentation that resident #1 has been educated on the right to question or refuse a medication if the resident believes there may be a medication error.

There was no documentation that resident #4 has been educated on the right to question or refuse a medication if the resident believes there may be a medication error.

191 - Resident Right to Refuse *(continued)*

Plan of Correction ***Accept [redacted] 07/24/2025)***

Deficiency: There was no documentation verifying that the resident was educated on their right to question or refuse a medication if they suspect a medication error, as required under resident rights regulations.

Plan of Correction
Immediate Corrective Action Taken

On 6/26/25, the resident in question was re-educated on their rights, including the right to question, refuse, or request clarification on any medication.

A Resident Rights Acknowledgment Form was signed by the resident and placed in their record, verifying that the information was reviewed and understood.

Identification of Other Residents Affected

A full audit of resident files was conducted to ensure that all residents had current documentation showing education on medication rights.

Any resident lacking this documentation was immediately re-educated, and acknowledgment forms were completed and filed.

Measures to Prevent Recurrence

The admission and annual review process has been revised to include a specific section on medication rights, including:

The right to question any medication

The right to refuse medication

The right to receive information on each prescribed medication

A Resident Rights Checklist is now required to be completed and signed during admission and annual re-education.

All forms are now reviewed by the Administrator or designee for completeness before being filed.

Staff Training

On 07/23/25, all staff will be retrained on:

Resident rights related to medication administration

How to respond when a resident questions or refuses a medication

Documentation procedures for resident education and refusal

191 - Resident Right to Refuse (continued)

Monitoring and Quality Assurance

The Administrator or designee will review resident rights documentation during all new admissions and as part of the annual audit process.

A random sample of 10% of resident files will be audited monthly for 3 months, then quarterly, to ensure continued compliance.

Any gaps will result in immediate re-education and documentation.

Responsible party: [redacted]. will be responsible for ensuring the implementation and ongoing compliance with this plan.

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

Implemented [redacted] - 08/26/2025)

224a - Preadmission Screen Form

15. Requirements

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

Description of Violation

The cognitive screening portion of the preadmission form dated [redacted]/25, for resident #3 indicated the resident's needs require a secured dementia care unit (SDCU) due to [redacted] or dementia, however, the home does not have a SDCU.

The home's preadmission screenings were not documented on the Department's preadmission screening form.

Plan of Correction ***Accept [redacted] - 07/24/2025)***

Deficiency: The pre-admission cognitive screening, dated [redacted], 2025, for Resident #3 indicated that the resident's needs required placement in a secure dementia care unit due to Alzheimer's disease or related dementia. However, the home does not have a secure dementia care unit, and thus is not equipped to meet those care needs.

Plan of Correction
Immediate Corrective Action Taken

Upon identification of this oversight, an immediate care team meeting was held on 6/27/25 to assess Resident #3's current safety and care status.

The resident's responsible [redacted] was contacted, and alternative placement options appropriate for secure dementia care were discussed.

224a - Preadmission Screen Form (continued)

Identification of Other Residents Affected

A full review of all current residents' pre-admission assessments and cognitive screening documents was conducted.

No other residents were found to be inappropriately placed based on their cognitive or behavioral needs.

The pre-admission process was re-examined to ensure all current residents are appropriate for a non-secure care setting.

Measures to Prevent Recurrence

The Pre-Admission Assessment Policy has been updated to include:

A mandatory review and sign-off by the Administrator or designee verifying that the resident's needs align with the services and physical environment the home can provide.

A defined exclusion criteria list, which includes conditions requiring a secure dementia care unit.

Pre-admission assessments that indicate dementia-related wandering, exit-seeking, or behavioral safety concerns will automatically trigger a secondary administrative review.

Staff Training

On 07/23/25, all admissions, administrative, and nursing staff were retrained on:

Criteria for appropriate resident placement

How to interpret cognitive screening results

Protocol for rejecting inappropriate admissions

Documentation and communication standards for transfers and referrals

Monitoring and Quality Assurance

All pre-admission packets will be reviewed by the Administrator prior to admission to confirm that resident needs are appropriate for the level of care offered.

Admissions will be monitored monthly for six months to verify compliance with the new screening and approval process.

Findings and trends will be discussed during QA/QI meetings and corrective action taken as needed.

Responsible party: [redacted] *. will be responsible for ensuring the implementation and ongoing compliance with this plan.*

224a - Preadmission Screen Form *(continued)*

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

Implemented [redacted] - 08/26/2025)

225a - Assessment 15 Days

16. Requirements

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

Description of Violation

Resident #3's assessment, dated [redacted] 25, indicated the resident is moderately immobile, however, the medical evaluation, dated [redacted] /25, indicated the resident is totally immobile.

Resident #3's assessment, dated [redacted] /25, indicated the resident has no special dietary needs, however, the medical evaluation, dated [redacted] /25, indicated the resident is ordered a mechanical soft diet.

Plan of Correction ***Accept [redacted] - 07/24/2025)***

Deficiency:
Resident #3's assessment dated [redacted] 2025, indicated the resident is moderately immobile and has no special dietary needs. However, the medical evaluation dated [redacted] 2025, documented the resident as totally immobile and requiring a mechanical soft diet. These discrepancies resulted in an inaccurate resident assessment.

Plan of Correction
Immediate Corrective Action Taken

The assessment for Resident #3 was immediately reviewed and corrected to reflect the accurate clinical information provided in the medical evaluation.

Nursing and dietary staff were notified of the correct mobility status and dietary order to ensure that appropriate care and meal preparation were provided without delay.

The resident's care plan and service plan were updated to reflect these corrections on 6/26/25.

Identification of Other Residents Affected

A review of all current resident assessments and corresponding medical evaluations was completed to identify any additional discrepancies.

Any inconsistencies found were corrected, and care plans updated accordingly.

No further residents were found to be affected.

Measures to Prevent Recurrence

A new Assessment-to-Medical Evaluation Cross-Check Protocol has been implemented. All resident assessments

225a - Assessment 15 Days (continued)

will be:

Cross-referenced with the most recent medical evaluation before finalization.

Reviewed by a licensed nurse and the Administrator or designee for accuracy.

A checklist is now used during assessments to ensure that mobility and dietary needs are verified against physician documentation.

Staff Training

On 07/23/25, nursing, dietary, and admissions staff will be retrained on:

Accurately interpreting and transferring information from medical evaluations to resident assessments

The importance of verifying mobility status and dietary orders directly with licensed healthcare providers

Proper documentation standards and communication across departments

Monitoring and Quality Assurance

The Administrator or designee will audit 10% of all new and updated resident assessments monthly for 3 months, then quarterly.

Discrepancies will be documented and addressed immediately, with staff feedback and corrective coaching as needed.

QA/QI meetings will include a standing item for discussing assessment accuracy and coordination between departments.

Responsible party: [redacted]*. will be responsible for ensuring the implementation and ongoing compliance with this plan.*

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

Implemented [redacted] ***- 08/26/2025)***

227c - Support Plan Revision

17. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #5's support plan, dated [redacted]*/24, indicated a personal needs account (PNA) will be made at the facility and*

227c - Support Plan Revision (continued)

documentation will be kept. However, direct care staff person E indicated the home does not manage finances or hold money for any of the home's residents.

Plan of Correction ***Accept [redacted] - 07/24/2025)***

Deficiency: Resident #5's support plan dated [redacted], 2024, incorrectly states that a Personal Needs Account (PNA) will be maintained at the facility with documentation kept. However, according to Direct Care Staff Person E, the facility does not manage or hold any resident funds. This inaccurate information represents a documentation error and may cause confusion or miscommunication regarding the home's financial responsibilities.

Plan of Correction
Immediate Corrective Action Taken

The incorrect statement in Resident #5's support plan was identified and immediately corrected on 6/26/25. The revised plan accurately reflects that the facility does not manage finances or hold money for any resident.

The resident and/or their responsible party were notified of the correction, and a revised support plan was signed and filed.

Identification of Other Residents Affected

A review of all current resident support plans was completed to identify any similar errors.

No additional support plans were found to incorrectly state that the home manages resident funds. If any had been found, they would have been corrected immediately with proper documentation and notification.

Measures to Prevent Recurrence

A Support Plan Review Checklist has been implemented to ensure all entries reflect the home's actual policies and services.

A section has been added to the support plan template to clearly indicate whether the facility manages personal funds, with a required check box and administrative sign-off.

Any future statements regarding financial management will require verification by the Administrator before the support plan is finalized.

Staff Training

On 07/23/25, all direct care and administrative staff responsible for writing or reviewing support plans will be retrained on:

The home's policy of not managing resident finances

How to ensure support plan entries reflect current services

Proper procedures for correcting documentation errors and informing responsible parties

227c - Support Plan Revision (continued)

Monitoring and Quality Assurance

The Administrator or designee will review all support plans monthly for 3 months, then quarterly, to verify alignment with the facility's scope of services.

Any inaccuracies will be corrected immediately, and staff responsible will receive additional coaching.

Responsible party: [redacted] *. will be responsible for ensuring the implementation and ongoing compliance with this plan.*

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

Implemented [redacted] ***- 08/26/2025)***