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

August 12, 2025

[redacted]
AB DRESHER OPERATOR LLC
[redacted]

RE: BRANDYWINE SENIOR LIVING AT
DRESHER ESTATES
1405 NORTH LIMEKILN PIKE
DRESHER, PA, 19025
LICENSE/COC#: 14424

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/26/2025 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: *BRANDYWINE SENIOR LIVING AT DRESHER ESTATES* **License #**: *14424* **License Expiration**: *07/02/2025*

Address: *1405 NORTH LIMEKILN PIKE, DRESHER, PA 19025*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *AB DRESHER OPERATOR LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/25/2001* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *96* **Waking Staff**: *72*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *06/26/2025*

Inspection Dates and Department Representative

06/26/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *112* **Residents Served**: *62*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Along the Journey* **Capacity**: *25* **Residents Served**: *19*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *62*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *34*

Have Physical Disability: *0*

Inspections / Reviews

06/26/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/21/2025*

07/28/2025 - POC Submission

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

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

Inspections / Reviews *(continued)*

08/07/2025 Document Submission

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

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/12/2025*

08/12/2025 Document Submission

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

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

51 - Criminal Background Check

1. 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

The criminal background for staff person A was completed on [redacted] staff person A's date of hire is [redacted].

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: During transition to Priority Life Care in February 2025, background checks were completed for employees. On June 17, 2025, an audit of all current personnel records was conducted by the Administrative Assistant to ensure background checks had been completed for the transition to Priority Life Care.
Training: On 7/2/25, Executive Director and Administrative Assistant were educated on regulation 2600.51 by the Regional Director of Operations. Training records will be kept.
Ongoing: Effective 7/21/25, Executive Director and/or Administrative Assistant will review new hire files x 3 months to ensure background check was completed prior to scheduling orientation. Background check to be kept in the employee file and outcome to be reviewed at monthly Quality Assurance Meetings beginning August 21, 2025, by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of the criminal background checks, and documentation will be kept.

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

Implemented [redacted] - 08/07/2025)

65f - Training Topics

2. 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.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person B and C did not receive the following training in 2024:

- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*
- *Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.*

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: During transition to Priority Life Care in February 2025, Relias training modules were updated to ensure training topics met Regulation 2600.65F. On 7/17/25, Relias Training Modules were reviewed by the Executive Director to ensure Regulation 2600.65f continues to be met.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Managers on the importance of completing the training as related to 2600.65f. Documentation of training will be kept.

65f Training Topics (continued)

Ongoing: Effective 7/21/25, Executive Director or Administrative Assistant will complete monthly audits x 3 months to ensure all monthly assigned Relias training modules are completed by current employees. Documentation of audit to be kept and reviewed at monthly quality assurance meetings beginning August 21, 2025 by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of Relias Training, documentation will be kept.

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

Implemented [redacted] 08/07/2025)

65g - Annual Training Content

3. 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:
5. Falls and accident prevention.

Description of Violation

Staff person B did not receive training in falls and accident prevention during 2024 training year.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: During transition to Priority Life Care in February 2025, Relias training modules were updated to ensure training topics met Regulation 65F. On 7 17/25, Relias Training Modules were reviewed by the Executive Director to ensure Regulation 65g continues to be met.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on the importance of completing the Relias training as related to 2600.65g. Training records wlll be kept.
Ongoing: Effective 7/21/25, Executive Director or Administrative Assistant will complete monthly audits x 3 months to ensure all monthly assigned Relias training modules are completed by current employees. Documentation of audit to be kept and reviewed at monthly quality assurance meetings beginning August 21, 2025 by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of Relias Training, documentation will be kept.

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

Implemented [redacted] - 08/07/2025)

82c - Locking Poisonous Materials

4. 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

In the memory care courtyard at 10am, there was an unlocked, unattended, and accessible to resident's sandbag on the ground, with manufacture's label indicating to that states get medical attention "if breathed in." All the residents of the home in the secured dementia care unit been assessed and are not capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] 07/28/2025)***

Action: On 6/26/25, the sandbag was removed from the courtyard by the Maintenance Director and placed in the dumpster. On 6/26/25, Memory Care courtyard was checked and fertilizer was also removed and placed in our dumpster.

82c - Locking Poisonous Materials (continued)

Training: Staff will be re educated by 7/18/25 by Executive Director or Department Manager on regulation 2600.82c, in regards to locking of poisonous material such as play sand. Documentation of training will be kept.
Ongoing: Effective 7/21/25 the Executive Director, Director of Nursing or Maintenance Director to complete daily rounds x 1 month, then weekly rounds x 3 months to ensure the courtyard of the dementia unit is free of sandbags and any poisonous materials. Documentation of audit to be kept and reviewed at monthly quality assurance meetings beginning August 21, 2025 by the Executive Director.. Starting 7/21/25, Executive Director will monitor completion of Memory Care courtyard rounds, documentation will be kept.

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

Implemented [redacted] - 08/07/2025)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

At 10:30 am, during the initial walk-through feces was observed in resident bathroom [redacted], resident bathroom [redacted] and resident bathroom [redacted].

At 2:45 pm, during the kitchen inspection, the ice cream lids in the freezer had ice-cream smeared substance on top of the lid and the lids in the ice cream freezer are not closing properly leaving the ice cream tub unsealed.

Plan of Correction ***Accept [redacted] 07/28/2025)***

Action: On 6/26/25, resident bathroom [redacted], resident bathroom [redacted] and resident bathroom [redacted] was immediately cleaned and sanitized. All bathrooms were inspected by Maintenance Director on 6/27/25 to ensure sanitary conditions were met. On 6/26/25, ice cream containers were covered with original ice cream lid. On 7/15/25, the original ice cream lid was replaced with plastic ice cream lids.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on regulation 2600.85a in regards to ensuring bathrooms are sanitary and ice cream being kept sealed. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Maintenance Director or Department Manager will conduct a random audit sampling of 10 rooms in the community daily to ensure resident bathrooms are in sanitary condition x 1 month, then weekly x 3 months. Effective 7/21/25, Dining Director or Executive Director to conduct daily rounds x 1 month and then weekly x 3 months to ensure ice cream is sealed and stored in sanitary condition. Documentation to be kept and reviewed at monthly quality assurance meetings beginning August 21, 2025 by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of resident bathroom rounds and completion of checking placement of ice cream lids , documentation will be kept.

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

Implemented ([redacted] - 08/07/2025)

86b - Bathroom

6. Requirements

86b - Bathroom *(continued)*

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom in resident room [redacted] and [redacted] does not have an operable window or ventilation fan.

Plan of Correction ***Accept ([redacted] - 07/28/2025)***

Action: On 7/7/25 and 7/9/25, Tustin Mechanical was out to inspect the exhaust fan ventilation system. Documentation of findings will be kept. Maintenance Director checked all memory care bathrooms on 6/27/25, Exhaust fans in memory care bathrooms were not operable. On 7/11/25 and 7/14/25 Tustin Mechanical began repairs to rooftop exhaust fan motors.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on regulation 2600.86b in regards to ensuring bathrooms have working exhaust fans. Documentation of training will be kept.
Ongoing: Effective 7/21/25. Maintenance Director or Executive Director will conduct a random audit sampling 10 rooms per day of resident bathrooms daily x 1 month then weekly x 3 months to ensure resident bathrooms have proper working ventilation. Documentation to be kept and reviewed at monthly quality assurance meetings beginning August 21, 2025, by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of exhaust fan room rounds, documentation will be kept

Licensee's Proposed Overall Completion Date: *08/14/2025*

Implemented [redacted] - 08/07/2025)

87 - Lighting

7. Requirements

2600.
87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

At 11am, during the initial physical site walk through the stairwell exit near room [redacted] the light was not operable.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: On 6/26/25, light bulb was replaced in the stairwell exit near room #223 and all stairwell lighting was checked by the Maintenance Director; no further findings identified.
Training: Staff will be reeducated by 7/18/25 by Executive Director or Department Manager on regulation 2600.87 as it relates to lighting in stairwells. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Maintenance Director or Executive Director will complete daily rounds x 1 month, then weekly rounds x 3 months to ensure all stairwell lighting is operable. Documentation of findings will be kept and reviewed at monthly Quality Assurance meetings beginning August 21, 2025, by the Executive Director. Starting 7/21/25, Executive Director will monitor the completion of stairwell lighting rounds, and documentation will be kept.

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

Implemented [redacted] - 08/07/2025)

88a Surfaces

8. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

At 10:30 am, the ceiling in resident room [redacted] had water stains.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: On 6/26/25, Maintenance Director cleaned the ceiling in resident room [redacted] All memory care ceilings were checked 7/17/25 and are free of stains. On 7/3/25, Roofing contractor was onsite to check roof, no issues were identified.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on regulation 2600.88a as it relates to ensuring rooms/ceilings are kept clean. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Maintenance Director or Executive Director to complete daily rounds x 1 month, then weekly rounds x 3 months to ensure surfaces are clean and in good repair and free of hazards. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, the Executive Director will monitor the completion of clean surfaces rounds, and documentation will be kept.

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

Implemented [redacted] - 08/07/2025)

95 Furniture and Equipment

9. Requirements

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

Description of Violation

At 10:30am, the smoke detector in resident room [redacted] was hanging from the ceiling.

At 2:30pm, during the kitchen inspection the prep refrigerator was out of order and the prep food tray were placed inside the Walkin refrigerator.

Plan of Correction ***Accept ([redacted] - 07/28/2025)***

Action: On 6/26/25, the Maintenance Director rehung the smoke detector in resident room #18. All memory care smoke detectors were checked on 7/17/25 by the Maintenance Director, no further issues noted. On 6/27/25, the Maintenance Director removed the prep refrigerator from the kitchen. On 6/27/25, the Dining Director checked all equipment in the kitchen, no further issues noted.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on regulation 2600.95 as it relates to furniture and equipment being in good repair, clean and free of hazards. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Maintenance Director, Maintenance Assistant or Executive Director will conduct daily rounds x 1 month, then weekly rounds x 3 months to ensure smoke detectors are in good repair. Dining Director, Cook or Executive Director will conduct daily rounds x 1 month, then weekly rounds x 3 months to ensure that kitchen equipment is in good repair, clean and free of hazards. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025 by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of maintenance rounds relating to smoke detectors and monitor completion of kitchen equipment rounds relating to ensuring proper working kitchen equipment, documentation

95 Furniture and Equipment (continued)

will be kept.

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

Implemented [redacted] - 08/07/2025)

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 [redacted] and Resident [redacted] does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: On 6/26/25, Director of Nursing placed lamp of Resident [redacted] and Resident [redacted] within reach so that resident has access to turn on/off at bedside. On 7/4/25, Executive Director checked all resident rooms to ensure bedside lamps were in place, operable and in reach of the resident, no further findings noted.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on regulation 2600.101j7 as it relates to lamps being within reach at bedside and being operable. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Director of Nursing, Memory Care Nurse/Med Tech or Executive Director will conduct daily rounds x 1 month, then weekly rounds x 3 months to ensure Lamps are within reach and operable. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, the Executive Director will monitor the completion of room rounds in regards to operable and in reach lamps. Documentation will be kept.

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

Implemented [redacted] - 08/07/2025)

102h - Toilet Paper

11. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

At 10:30 am, there was no toilet paper for the toilet in bathroom [redacted].

Plan of Correction ***Accept ([redacted] - 07/28/2025)***

Action: On 6/26/25, Housekeeper provided toilet paper in bathroom [redacted]. Housekeeping Coordinator checked all resident bathrooms on 6/26/25 to ensure a supply of toilet paper was available.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on regulation 2600.102h as it relates to ensuring toilet paper is being provided and available in the resident bathroom. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Housekeeping Coordinator or Executive Director will conduct daily rounds x 1 month, then weekly rounds x 3 months to ensure toilet paper is being provided and available in resident bathroom.

102h Toilet Paper (continued)

Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025 by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of room rounds in regards to toilet paper being available, documentation will be kept.

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

Implemented [redacted] 08/07/2025)

103c - Food Protected

12. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

There were trays of hotdogs and cabbage inside the food warmers on top of serving plates for the residents.

Plan of Correction ***Accept [redacted] 07/28/2025)***

Action: On 6/26/25, Dining Director discarded the tray of hotdogs and cabbage and rewashed the serving plates. On 6/26/25, Dining Director checked the warmer during dinner meal and no issues were noted.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on regulation 2600.103c as it relates to ensuring food is protected from cross contamination. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Dining Director or Executive Director will conduct daily rounds x 1 month, then weekly rounds x 3 months to ensure there is no cross contamination of food. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting on 7/21/25, Executive Director will monitor completion of rounds in regards to ensuring no food cross contamination, documentation will be kept.

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

Implemented [redacted] - 08/07/2025)

103g - Storing Food

13. Requirements

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

Description of Violation

The rice, pasta and beans in the food pantry was opened and unsealed.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: On 6/26/25, Dining Director discarded the rice, pasta and beans that were open and not sealed. Other unopened bags of rice, pasta, and beans were placed in sealed containers. On 6/26/25 Dining Director completed an inspection of the kitchen to ensure all food was in containers.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on regulation 2600.103g as it relates to ensuring food is stored in sealed containers. Documentation of training will be kept.

103g - Storing Food (continued)

Ongoing: Effective 7/21/25, Dining Director or Executive Director will conduct daily rounds x 1 month, then weekly rounds x 3 months to ensure food is being kept in sealed containers. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, the Executive Director will monitor completion of rounds in regards to ensuring no food cross contamination and documentation will be kept.

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

Implemented [redacted] - 08/07/2025)

103i - Outdated Food

14. Requirements

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

Description of Violation

There were two cans of sliced peaches with an expiration date of [redacted] and one can of sliced pineapple with an expiration date of [redacted] in the food pantry.

There was an unlabeled, undated frozen corn, chicken patties and cheese in the freezer and fridge.

Plan of Correction ***Accept [redacted] 07/28/2025)***

Action: On 6/26/25, Dining Director discarded the two cans of sliced peaches and one can of sliced pineapple with past expiration dates, as well as discarded the unlabeled, undated frozen corn, chicken patties and cheese. On 6/26/25, Dining Director completed an inspection of the kitchen, no further outdated food was found.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on regulation 2600.103i as it relates to ensuring food past expiration date is discarded as well as labeling/dating of food being kept in the freezer and refrigerator. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Dining Director or Executive Director will conduct daily rounds x 1 month, then weekly rounds x 3 months to ensure food is being labeled and dated and food with past expiration dates is being discarded. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of rounds in regards to ensuring no expired food is in the kitchen. Documentation will be kept.

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

Implemented [redacted] - 08/07/2025)

107c - Food/Water 3 Day Supply

15. Requirements

2600.

107c - Food/Water 3 Day Supply *(continued)*

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On [redacted] the home served 60 residents, requiring 180 gallons of emergency drinking water. However, the home had only 45 gallons. The home does not have a contract with a local bottled water supplier that includes 24-hour service.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: On 6/30/25, order was placed for emergency water replenishment. On 7/18/25, Executive Director received letter from contracted food vendor in regards to emergency food and water supply delivery.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on regulation 2600.107c as it relates to ensuring 3 day emergency supply of non perishable food and water is kept onsite. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Dining Director or Executive Director will conduct daily rounds x 1 month, then weekly rounds x 3 months to ensure emergency food and water supply is being kept at appropriate par level based upon census. Documentation of findings will be kept and reviewed monthly Quality Assurance meeting beginning August 21, 2025 by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of rounds in regards to ensuring Emergency Food Supply par level meets regulation compliance. Documentation will be kept.

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

Implemented [redacted] - 08/07/2025)

121a - Unobstructed Egress

16. 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

On [redacted] at 9:20am, the exit in the first-floor dining room had a dinning chair placed in front of the exit creating a blocked egress while the residents were eating in the dining room.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: On 6/26/25, dining room chair was removed by dining employee from blocking the dining room door and placed at the appropriate table. On 6/26/25, all points of egress were checked by the Executive Director and Maintenance Director and no further findings were identified.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Manager on regulation 2600.121a as it relates to ensuring exit doors are unlocked and unobstructed. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Executive Director will conduct daily rounds x 1 month, then weekly rounds x 3 months to ensure exit doors remain unlocked and unobstructed. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of rounds in regards to ensuring means of egress remain unblocked. Documentation to be kept.

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

121a - Unobstructed Egress *(continued)*

Implemented [redacted] - 08/07/2025)

141a - Medical Evaluation

17. 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.

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. There is no record of a medical evaluation.

Plan of Correction ***Directed ([redacted] - 07/28/2025)***

Action: On 7/18/25, a tickler file system for the community has been completed in regards to Medical Evaluation forms by the Director of Nursing and Executive Director. Residents identified with missing or outdated Medical Evaluation Forms will have new forms completed.
Training: Director of Nursing and Executive Director were educated on 7/2/25 by the Regional Director of Operations on regulation 2600.141a as it relates to ensuring medical evaluation is completed within 60 days prior to admission and 30 days after admissions. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Director of Nursing and Executive Director will review and approve medical evaluation form prior to new admission into the home. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, Executive Director will monitor the completion of the Medical Evaluation form to ensure the date of compliance is being met. Documentation to be kept.

Directed Plan of Correction ([redacted] 7/28/25):

-The Director of Nursing will obtain or schedule a medical evaluation for resident #3 within 10 days of receipt of this plan of correction. Documentation of the DME will be available for review by the Department.

Proposed Overall Completion Date: 08/07/2025

Directed Completion Date: *08/08/2025*

Implemented ([redacted] - 08/12/2025)

141b1 - Annual Medical Evaluation

18. Requirements

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

Description of Violation

Resident [redacted]s medical evaluation was not completed in 2025. The resident's most recent medical evaluation was completed on [redacted]

141b1 - Annual Medical Evaluation (continued)

Resident [redacted]s medical evaluation was not completed in 2025. The resident's most recent medical evaluation was completed on [redacted].

Plan of Correction ***Accept [redacted] - 07/28/2025)***

ACTION: On 7/18/25, a tickler file system for community was completed in regards to Annual Medical Evaluation by the Director of Nursing and Executive Director to ensure compliance with annual medical evaluations.
Resident [redacted] was seen by the Provider on 7/15/25, and the annual medical evaluation was completed. Director of Nursing has scheduled Resident [redacted] for annual evaluation on 7/24/25.
TRAINING: Director of Nursing and Executive Director were educated on 7/2/25 by the Regional Director of Operations on regulation 2600.141b1 as it relates to Annual Medical Evaluations. Training records will be kept.
ONGOING: Effective 7/21/25, Director of Nursing and Executive Director will review Tickler daily to ensure annual medical evaluations are done timely. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, Executive Director will monitor the completion of the Medical Evaluation form to ensure the date of compliance is met. Documentation to be kept.

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

Implemented [redacted] - 08/12/2025)

184a - Resident's Meds Labeled

19. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for resident [redacted] does not include the change of order for the following medications:

- *[redacted]L inject 6 units under the skin before lunchtime was discontinued on [redacted]. On [redacted] Resident was prescribed [redacted] inject 8 units under the skin before lunchtime. The medication in the cart did not have a change of order sticker.*

- *[redacted] inject 22 units subcutaneously at bedtime was discontinued on [redacted]. On [redacted], Resident was prescribed [redacted] inject 25 units at bedtime. The medication in the cart did not have a change of order sticker.*

Plan of Correction ***Accept ([redacted] - 07/28/2025)***

Action: On 6/26/25, Director of Nursing, placed appropriate change of order label to Resident [redacted] Pen and [redacted]. The Director of Nursing reviewed medication carts to ensure medications were labeled properly and change forms stickers were in place where indicated.

184a - Resident's Meds Labeled (continued)

Training: Nurses and Medication Technician staff will be educated by 7/18/25 by the Director of Nursing on regulation 2600 2600.184a as it relates to medications being labeled properly when orders change. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Director of Nursing or Executive Director will conduct weekly medication cart audits x 1 month, then monthly audits x 3 months to ensure medications are labeled properly when medication changes are made. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of medication cart audits. Documentation to be kept.

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

Implemented [redacted] - 08/07/2025)

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 [redacted] is prescribed [redacted] order to take every 6 hours as needed for anxiety. On [redacted], the medication was not available in the home.

Resident [redacted] is prescribed [redacted] as needed for pain. On [redacted] the medication was not available in the home.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: On 6/26/25, Director of Nursing contacted contracted Pharmacy. Medication was reordered and delivered on the same day, 6/26/25, in the evening. Medications in cart were reviewed against Physician orders, no other missing medication was identified.
Training: Nurses and Medication Technician Staff will be educated by 7/18/25 by the Director of Nursing on regulation 2600.185a as it relates to safe storage and access to medications. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Director of Nursing or Executive Director will conduct weekly medication cart audits x 1 month, then monthly audits x 3 months to ensure medications are stored properly and readily available. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, the Executive Director will monitor completion of medication cart audits. Documentation to be kept.

185a Implement Storage Procedures *(continued)*

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

Implemented [redacted] - 08/07/2025)

187d - Follow Prescriber's Orders

21. Requirements

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

Description of Violation

Resident [redacted] is prescribed to check blood sugar four times daily in the morning before breakfast at 7:30am, before lunch at 11:30am and before dinner at 4pm and bedtime 8pm. On [redacted] the facility only completed the blood sugar check at 6:21pm and on [redacted] the facility only completed the blood sugar check at 5:31pm.

Resident [redacted] is prescribed [redacted] 4 times a day at 8am, 12pm, 5pm, 8pm. On [redacted] the medication was not administered to the resident because it was not available in the home.

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: On 6/26/25, the Director of Nursing changed blood sugar check time for Resident [redacted] to accommodate [redacted] family outings. On 6/26/25, the Director of Nursing contacted the contracted Pharmacy for Resident [redacted]6, and the medication was reordered and delivered the same day.
Training: Nurses and Medication Technician Staff will be educated by 7/18/25 by the Director of Nursing on regulation 2600.187d as it relates to timeliness of blood sugar checks and following prescriber's orders. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Director of Nursing or Medication Nurse/Tech will conduct weekly glucose documentation audits x 1 month, then monthly audits x 3 months to ensure blood sugar checks are completed timely. Effective 7/21/25, Director of Nursing or Nurse/Med Tech will conduct weekly medication cart audits x 1 month, then monthly audits x 3 months to ensure prescriber's orders are being followed. Documentation of findings will be kept and reviewed at monthly Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, Executive Director will monitor completion of medication cart audits. Documentation to be kept.

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

Implemented [redacted] - 08/07/2025)

224a - Preadmission Screen Form

22. Requirements

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

Description of Violation

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

224a - Preadmission Screen Form (continued)

Plan of Correction ***Accept (- 07/28/2025)***

Action: On 7/18/25, a tickler file system for community has been completed in regards to Medical Evaluation forms by the Director of Nursing and Executive Director. An area of opportunity has been identified and a plan to correct is in place.
Training: Director of Nursing and Executive Director were educated on 7/2/25 by the Regional Director of Operations on regulation 2600.224a as it relates to Preadmission Screen Form to ensure resident needs can be met by the services provided by the home and ensure Preadmission Screen Form is being completed within 30 days prior to the admission to the home. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Director of Nursing and Executive Director will review and approve Preadmission Screen Forms prior to new admission into the home. Documentation of findings will be kept and reviewed monthly at Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, the Executive Director will monitor completion of the Preadmission Screening form to ensure the date of compliance is being met. Documentation to be kept.

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

Implemented - 08/07/2025)

225a - Assessment 15 Days

23. 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 was admitted on the resident's assessment was not completed until

Plan of Correction ***Accept - 07/28/2025)***

Action: On 7/18/25, a tickler file system for the community was developed in regards to Initial Assessment by the Director of Nursing and Executive Director. An area of opportunity has been identified, and a plan to correct is in place.
Resident DME was received on 7/21/25.
Training: Director of Nursing and Executive Director were educated on 7/2/25 by the Regional Director of Operations on regulation 2600.225a as it relates to DME/Initial Assessment form completion within 15 days of admission.
Ongoing: Effective 7/21/25, Director of Nursing of Nursing and Executive Director will review and approve DME/ Initial Assessment form prior to new admission into the home. Documentation of findings will be kept and reviewed monthly at Quality Assurance meeting beginning August 21, 2025, by the Executive Director. Starting 7/21/25, the Executive Director will monitor completion of PreAdmission Screening form to ensure date of compliance is being met. Documentation to be kept.

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

Implemented - 08/07/2025)

236 - Staff Training

24. Requirements

236 Staff Training *(continued)*

2600.

236. Training Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

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

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Action: During transition to Priority Life Care in February 2025, Relias training modules were updated to ensure training topics met Regulation 2600.236. On 7/17/25, Relias Training Modules were reviewed by the Executive Director to ensure Regulation 2600.236 continues to be met.
Training: Staff will be educated by 7/18/25 by the Executive Director or Department Managers on the importance of completing the training as related to 2600.236. Documentation of training will be kept.
Ongoing: Effective 7/21/25, Executive Director or Administrative Assistant will complete monthly audits x 3 months to ensure all monthly assigned Relias training modules are completed by current employees. Documentation of audit to be kept and reviewed at monthly quality assurance meetings beginning August 21, 2025, by the Executive Director. Starting 7/21/25, Executive Director will monitor the completion of Relias Training, with documentation kept.

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

Implemented ([redacted] - 08/07/2025)