pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ALEXANDRIA MANOR OF ALLENTOWN, INC.**
LEGAL ENTITY

To operate **ALEXANDRIA MANOR OF ALLENTOWN - BETHLEHEM CAMPUS**
NAME OF FACILITY OR AGENCY

Located at **3534 LINDEN STREET, BETHLEHEM, PA 18017**
(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 **58**
(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 **December 12, 2025** until **June 12, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **214561**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

Pennsylvania
Department of Human Services

Sent via email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 12, 2025

[redacted]
Alexandria Manor of Allentown, Inc.
[redacted]

RE: Alexandria Manor at Allentown –
Bethlehem Campus
3534 Linden Street
Bethlehem, Pennsylvania 18017
License: 214561

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) licensing inspections on June 26, 2025, August 28, 2025, and September 8, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 214560) dated September 29, 2025, to September 29, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being based on the violations attached to this notice and mistreatment or abuse of residents being cared for in the facility. The license dated September 29, 2025 to September 29, 2026 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from DECEMBER 12, 2025 to JUNE 12, 2026.

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

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

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

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

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *ALEXANDRIA MANOR OF ALLENTOWN - BETHLEHEM CAMPUS* **License #**: *21456* **License Expiration**: *09/29/2026*

Address: *3534 LINDEN STREET, BETHLEHEM, PA 18017*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *ALEXANDRIA MANOR OF ALLENTOWN, INC.*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/04/2006* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *43* **Waking Staff**: *32*

Inspection Information

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

Reason: *Incident, Interim* **Exit Conference Date**: *09/08/2025*

Inspection Dates and Department Representative

08/28/2025 - On-Site: [redacted]

09/08/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served**: *42*

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: *42*

Diagnosed with Mental Illness: *4*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *1*

Have Physical Disability: *1*

Inspections / Reviews

08/28/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/06/2025*

11/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/14/2025*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

11/18/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *11/14/2025*

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

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Staff reported that resident #1 was exit seeking since being admitted on [redacted]/25. On 8/20/25, resident #1 was seen by a certified registered nurse practitioner for a medication adjustment related to an increase in aggression toward staff and for exit seeking behavior. However, staff were not instructed to implement one-to-one supervision or 15-minute checks for the resident. The home also did not look for alternative placement in a secured dementia care unit to ensure resident #1's safety. Staff person A reported that on [redacted]22/25 at 5:30 a.m., they saw resident #1 exit the 1st floor but was able to stop the resident in the parking lot. Resident #1 was redirected back to their room and got into bed. At 6:35 a.m., resident #1 walked out of the building again, unnoticed by staff and was later found by local police sitting on a curb. Resident #1 was sent to Lehigh Valley Hospital-Muhlenberg for treatment of a large bump on their head. The resident [redacted] on [redacted]25 from complications of a closed head injury secondary to their fall.

Plan of Correction ***Directed [redacted] - 11/13/2025)***

All residents have been assessed for any exit seeking behaviors to ensure appropriate interventions are implemented. This assessment occurred on [redacted] of Bath facility and [redacted]. No residents were found with exit seeking behaviors.

Department of Human Services was notified on 08/22/2025 by [redacted] facility of the Resident 1 elopement.

An investigation was completed by [redacted] of [redacted] and [redacted] as of 09/05/2025 specific to Resident # 1 elopement.

All Staff were educated on dementia residents specific to behaviors, elopements and exit seeking behavior with emphasis on staff interventions including reporting of exit seeking behavior, 24-hour report, what causes exit seeking behavior, interventions for exit seeking behavior, 1:1 monitoring, evaluation for mental status change and elopement procedures. Staff were also educated on the shift report and documentation and the need to include any changes in resident condition to include but not limited to exit seeking behaviors safety interventions in place, [redacted] facility on 09/11/2025. Please see attached education sheet from 09/11/2025 which was provided by Alexandria Manor; additional education was provided by AMI LTC Rise, Age Sensitivity on 10/21/2025 regarding understanding behaviors of residents with dementia.

Education will be provided on 11/14/2025 regarding regulation 42b abuse, along with education explaining why elopement is classified with abuse regulation. Signature documentation sheet will be provided once completed.

Education was also provided on 09/11/2025 to Personal Care Home [redacted]. Education was specific to role of administrator in reporting elopement timely, timely completion of an investigation and implementation of follow up interventions to assure implementation of a plan to reduce the risk of elopement and keep resident's safe. Additional education will be provided by PEPP Unlimited to [redacted] on 11/18/2025 with emphasis on foundations of supervision of

42b - Abuse (continued)

staff and residents.

Counseling was provided to the med tech knowledgeable of the exit seeking behavior on the date of elopement on 08/22/2025 by [redacted]. Additional counseling was also provided to med tech on 09/05/2025 [redacted] related to this incident and lack of reporting and follow up.

As of 11/7/2025 shift reports will be used as a tool to log information daily regarding residents and any types of changes seen either medical or cognitive. Audits will be completed daily times 6 months by the personal care home administrator or designee specific to identifying any resident who displays exit seeking behaviors and to assure an appropriate RASP is in place and to assess if any other interventions are required for identified residents safety which can include but not limited to, intermediate checks, transfer to hospital for evaluation of altered mental status, emergent 1:1 monitoring and or transfer to a different level of care including but not limited to a secured dementia unit requiring transfer to meet their safety needs.

All staff will be interviewed/questioned monthly by the personal care home administrator or designee related to their role and responsibility when they see or know of a resident who displays exit seeking behavior.
Elopement drills will now be implemented with first drill occurring 11/2025 and are to be completed quarterly by personal care home administrator. The emphasis of these drills will include initial identification of any behaviors of exit seeking to be addressed prior to an actual elopement when aware and what to do if a resident exit seeks including all intervention expectations, and finally what to do if an elopement occurs including reporting of same and follow up including investigation and review of all residents for high risk behavior of exit seeking.

[redacted] *as of 10/28/2025 has been added to Bethlehem facility license as a co-administrator for additional supervision and proper on-going compliance.*

[redacted] *will also be providing additional support and supervision in preparation for transfer to Alexandria Manor Bethlehem when credentialing is completed.*

[redacted] *are responsible for full ongoing compliance.*

Proposed Overall Completion Date: 11/06/2025

Directed: The home will review preadmission screening policy and procedures to include level of supervision needed prior to admission for all new residents. Update staff schedule accordingly to ensure new admission have proper supervision.
The home will develop and implement elopement prevention policies and procedures to address alarms on doors and resident's ability to reenter the building after exiting, preadmission screening process and adequate supervision of new residents.
Elopement prevention and elopement risk training will be provided at least every six months for all staff persons who work in the personal care home in both the secured dementia care unit and the non-secure section. Mock elopement drills will be conducted as part of the training.
Mock elopement drills will be documented to include date, time, name of staff person conducting the drill, whether staff followed proper procedures and problems encountered. Mock elopement drill

42b - Abuse (continued)

documentation will be immediately available to the Department upon request.
Within 30 days, an elopement risk assessment will be completed for each resident who resides in the personal care home, both the secure dementia care unit and the non-secure care section. Direct care staff will be consulted during the elopement risk assessment process. This assessment will be completed at least every six (6) months and more frequently if a resident demonstrates evidence of exit-seeking behavior.

Directed Completion Date: *12/08/2025*

183d - Prescription Current

2. Requirements

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

Description of Violation

The medication Diltiazem 24 H ER (CD), prescribed for resident #2, was in the home's medication cart on 8/28/25; however, the medication was discontinued on 7/31/25.

Plan of Correction ***Accept [redacted] - 11/13/2025)***

Upon notification during inspection on 08/28/25, [redacted] immediately pulled medication from medication cart and contacted Newhards Pharmacy; spoke to [redacted] to verify active prescription order. Newhards pharmacy stated the order was active within their system; they had a system issue, and it never ported from their order/fill screen to QuickMar which is our MAR (medication administration record) platform at the start of Aug 1, 2025 cycle change over.

Immediately following post exit conference on 08/28/2025 and continuing into the following day 08/29/2025, [redacted] facility audited all medication carts and MARs (medication administration record) to verify all medications, OTC and orders matched and were properly documented in MARs (medication administration record) for proper compliance.

All MedTech's including [redacted] were counseled and have received education [redacted] home administrator by 11/06/2025 in regard to regulation 183d only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home. With emphasis of education including all medications must be cross referenced with MAR (medication administration record) for proper documentation and proper compliance.

[redacted] as of 10/28/2025 and [redacted] audited all medication carts and MARs (medication administration records) on 11/03/2025 and found all to be in proper compliance. Audits will be completed of all medication carts and MARs (medication administration records) by [redacted] of 10/28/2025 and [redacted]

183d - Prescription Current (continued)

[redacted] *weekly times 5 weeks, bi-weekly times 2, then monthly times 5 months. During ongoing audits, education/training will be provided to designated staff in preparation for transitioning monthly medication carts and MARs (medication administration record) audits to staff within the facility for on-going compliance.*

[redacted] *are responsible for full ongoing compliance.*

Licensee's Proposed Overall Completion Date: *11/06/2025*

Not Implemented ([redacted] - 11/18/2025)

185a - Implement Storage Procedures

3. 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

The blister pack for the medication Tamsulosin, prescribed for resident #3, had been tampered with: the two capsules remaining in the blister pack both had tape placed over the backs of the slots.

Plan of Correction ***Accept ([redacted] - 11/13/2025)***

Upon notification during inspection on 08/28/25, [redacted] *immediately pulled medication from medication cart.*

Immediately following post exit conference on 08/28/2025 and continuing into the following day 08/29/2025, [redacted] *audited all medication carts to verify all medications and OTCs were in proper original container to maintain proper compliance.*

All MedTech's including [redacted] *were counseled and have received education by* [redacted] *by 11/06/2025 in regard to regulation 185a 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 with emphasis of education including all medications including, punch cards or bottle medication must be properly sealed and stored to maintain proper ongoing compliance.*

[redacted] *as of 10/28/2025 and* [redacted] *audited all medication carts on 11/03/2025 and found all medication punch cards and bottle medications to be in proper compliance. Audits will be completed of medication carts by* [redacted] *as of 10/28/2025 and* [redacted] *weekly times 5 weeks, bi-weekly times 2, then monthly times 5 months. During ongoing audits, education/training will be provided to designated staff in preparation for transitioning monthly medication carts audits to staff within the facility for on-going compliance.*

[redacted] *are*

185a - Implement Storage Procedures (continued)

responsible for full ongoing compliance.

Licensee's Proposed Overall Completion Date: *11/06/2025*

Not Implemented [redacted] - 11/18/2025)

187b - Date/Time of Medication Admin.

4. Requirements

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

Description of Violation

The medication Diltiazem 24 H ER (CD) prescribed for resident #2 was in the home's medication cart on 8/28/25 and was administered to resident #2 from 8/1/25 to 8/28/25 at 9 a.m. each day; however, the medication was not included on the resident's Medication Administration Record and therefore the information in 2600.187(a)(13) and 2600.187(a)(14) was not recorded at the time the medication was administered.
Repeated violation 10/10/24

Plan of Correction ***Accept [redacted] - 11/13/2025)***

Upon notification during inspection on 08/28/25, [redacted] immediately pulled medication from medication cart

Immediately following post exit conference on 08/28/2025 and continuing into the following day 08/29/2025, [redacted] audited all medication carts and MARs (medication administration record) to verify all medications, OTC and orders matched and were properly documented in MARs (medication administration record) for proper compliance.

All MedTech's including [redacted] were counseled and have received education by [redacted] by 11/06/2025 in regard to regulation 187b Date/Time of medication administration, with emphasis of education including all medications must be cross referenced with MAR (medication administration record) for proper documentation which includes regulation and subsections 187(a)(13) date and time of medication administration and187(a)(14) name and initials of the staff person administering the medication along with proper compliance.

[redacted] *as of 10/28/2025 and [redacted] audited all medication carts and MAR (medication administration record) on 11/03/2025 and found all to be in proper compliance. Audits will be completed of medication carts and MARs (medication administration records) by [redacted] as of 10/28/2025 and [redacted] weekly times 5 weeks, bi-weekly times 2, then monthly times 5 months. During ongoing audits, education/training will be provided to designated staff in preparation for transitioning monthly medication carts and MAR (medication administration record) audits to staff within the facility for on-going compliance.*

[redacted] *are*

187b - Date/Time of Medication Admin. (continued)

responsible for full ongoing compliance.

Licensee's Proposed Overall Completion Date: *11/06/2025*

Not Implemented [redacted] - 11/18/2025)

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

Facility Information

Name: *ALEXANDRIA MANOR OF ALLENTOWN - BETHLEHEM CAMPUS* **License #:** *21456* **License Expiration:** *09/29/2025*

Address: *3534 LINDEN STREET, BETHLEHEM, PA 18017*

County: *NORTHAMPTON* **Region:** *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *ALEXANDRIA MANOR OF ALLENTOWN, INC.*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/04/2006* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *46* **Waking Staff:** *35*

Inspection Information

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

Reason: *Renewal* **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: *58* **Residents Served:** *43*

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: *43*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *3*
Have Physical Disability: *1*

Inspections / Reviews

06/26/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/25/2025*

07/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/13/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/28/2025*

08/12/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/13/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/16/2025*

10/08/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/13/2025*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The batteries for the Carbon Monoxide monitor located in the kitchen were not labeled with a date the batteries were installed as required by the Care Facility Carbon Monoxide Alarms Standards Act.

Plan of Correction ***Accept [redacted] - 07/23/2025)***

Corrected at time of inspection, moving forward the batteries will be written on with the date and done every 6 months, June and December by the maintenance personnel, Ultimately it is this admins job to ensure it is done every 6 mos.

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

Implemented [redacted] - 10/08/2025)

20b1 - Financial Records

2. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

The home manages finances for Resident #1. On 1/6/25, the resident had an ending account balance of $135.00 when the statement was reviewed and sent. The new quarterly statement was started on 1/30/25 and the initial balance was documented as $130.00. There is no record of the $5.00 deficit.

Plan of Correction ***Accept [redacted] - 08/06/2025)***

Money was replaced, activity director either missed a tip to the hairdresser or a dunkin run. Assistant admin and Activity director will go through the money weekly when the money is used to ensure the count is correct, Ultimately it s this admins role to ensure it is done and the counts are correct
This will be checked weekly by both the asst admin and activity director when money is withdrawn or added to, again ultimately it is the responsibility of this admin to ensure it i done

8/5/2025-

Unaccounted for funds were replaced day of inspection.

Audit of all hairdresser funds were done on 8/5/25 by [redacted] and found to be in compliance.

20b1 - Financial Records (continued)

Moving Forward:

New hairdresser fund registers will be used starting 8/7/25 to include resident and double staff signature block in prevention of missed withdraws. [redacted], [redacted] and [redacted] will be doing weekly audits for 4 weeks, then monthly audits for 6 months to monitor and maintain proper ongoing compliance. Signature sheets will be provided. [redacted] [redacted] will be over seeing compliance and auditing all new hire charts, times 6 months to maintain proper compliance.

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

Implemented [redacted] - 10/08/2025)

51 - Criminal Background Check

3. Requirements

2600.

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

Description of Violation

Staff person A, who was hired [redacted]/25, did not have a criminal background check requested until 6/6/25.
Staff person B, who was hired [redacted]/25, did not have a criminal background check completed.
Repeated violation 10/10/24.

Plan of Correction ***Accept[redacted] - 08/06/2025)***

Both staff persons criminal background checks were shown to inspector on day, from this point on all criminal background checks will be done on day of hire and back before their first day of starting, ultimately it is the responsibility of this admin to ensure it is done and done correctly
Again they were done, just not in charts Ultimately it is this admins responsibility to ensure they are done and in their charts before starting their position

8/4/2025-

All employee charts were audited for hire and start dates on 8/2/2025, notations were made regarding status of start date.

Office staff educated on 8/4/2025 regarding reg 51 Criminal Background Check. The importance of following proper timelines in order to safely protect

51 - Criminal Background Check (continued)

our residents.

Moving Forward:

All new hires will not start until criminal check is back. All new hires will have a separate hire date, orientation date and start date to streamline and prevent new hires from starting before criminal check is back. [redacted], will be handling employee charts and sending criminal checks to [redacted] to be completed. [redacted] facility will be over seeing compliance and auditing all new hire charts, times 6 months to maintain proper compliance.

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

Implemented [redacted] - 10/08/2025)

65a - FS Orientation 1st Day

5. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was [redacted]/25, did not receive orientation on the required topics until 6/3/25.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

All new staff will be trained on the day they are hired before they start the job to ensure they are trained. Ultimately it is the responsibility of this admin to ensure it will be done. At this time we are fully staffed but moving forward this will be done I had miss read the whole thing and honestly thought I had the first 40 hr

65a - FS Orientation 1st Day (continued)

8/4/2025-

All employee charts were audited for first day orientation training on 8/2/2025, notations were made on charts regarding status of first day orientation training.

Office staff educated on 8/4/2025 regarding reg 65a FS Orientation 1st Day. The importance of proper initial orientation training to safely equip our staff to do their jobs appropriately.

Moving Forward:

All new hires will not start until first day orientation training is complete. All new hires will have a separate hire date, orientation date and start date to streamline and prevent new hires from starting before first day orientation training is complete. [redacted], will be handling employee charts and first day orientation training. [redacted] will be over seeing compliance and auditing all new hire charts, times 6 months to maintain proper ongoing compliance.

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

Implemented [redacted] - 10/08/2025)

65g - Annual Training Content

6. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person C did not receive training on resident rights during training year January 1, 2024 to December 31st 2024.

65g - Annual Training Content (continued)

Staff person D did not receive training on fire safety, resident rights, and falls and accident prevention during training year January 1, 2024 to December 31st 2024.
Repeated violation 10/10/24.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

Staff person C did have Residents Rights Training, see attached, Staff person D was in the hospital for that entire month and did not return until september and was forgotten about, moving forward all staff will be trained when they return on the mandatory inservices. Ultimately it s this admins responsibility to ensure everyone receive the training that is supposed to have. Staff D was given those inservice to bein compliances

8/4/2025-

Staff person C and Staff person D both have received trainings in question for 2025.

All employee charts were audited for annual training on 8/2/2025, all were found to be in compliance up to current time frame.

Office staff educated on 8/4/2025 regarding reg 65g - Annual Training Content. The importance of proper annual training to safely equip our staff to do their jobs appropriately.

Moving Forward:

[redacted] will be handling all employee charts and monitoring annual training compliance. Staff will be receiving individual annual training to properly maintain compliance. [redacted] will be over seeing compliance and auditing all employee charts/annual training for the remaining 2025 training year.

****Please see attached blank annual training signature sheet that will now be used****

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

65g - Annual Training Content *(continued)*

Implemented [redacted] 10/08/2025)

85a - Sanitary Conditions

7. Requirements

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

Description of Violation

At approximately 9:40 a.m. there was a strong odor of urine in the side hallway leading to the backyard patio.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

Both residents are competent but highly inc of both B&B functions, they are changed frequently however the odors have permeated the carpeting. The carpet is being replaced this week and vinyl is being put down to hopefully control the odor. Ultimately it is this admins responsibility to ensure that it is complete
Carpet was removed and vinyl was placed, odor is much better as it is easier to clean up after the inc episodes. Again it is this admins responsibility to ensure the odor is under control

8/4/2025

Room and carpet were cleaned day of inspection. Both residents involved were showered day of inspection as well.

Carpet was removed and vinyl flooring was installed 7/22/25 in room for more effective cleaning and hygienic practices.

All staff educated on 8/4/2025 regarding reg 85a Sanitary conditions, how to identify and handle odor issues within the facility.

Moving Forward:

Housekeeping staff is now using an enzyme eating cleaner that is specifically made for high traffic and urine concentrated areas. [redacted] will be over seeing compliance and randomly auditing all rooms and floors of the facility for the next 6 months to maintain proper compliance.

**** Please see attached picture of room with new flooring.****

85a - Sanitary Conditions (continued)

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

Implemented [redacted] - 10/08/2025)

92 - Windows

8. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At approximately 10:15 a.m. the window screens in the dining area on the 2nd and 3rd floors were torn and detached from the screen frame and in disrepair.

Plan of Correction ***Accept ([redacted]/12/2025)***

Screens are in the process of being repaired or replaced at this time. When completed I will send pictures to prove they were done. Ultimately it is the responsibility of this adnin to ensure the job is completely done
Screens are fixed, an d new ones are put in. It will be the responsibility of the maintenance personnel, assist admin and ultimately this admin to ensure they remain in good condition

8/4/25

Screens on second and third floor dining area have been replaced as of 7/8/25.

Audits of facility screens (common areas and resident rooms) have been completed and found to be in compliance as of 8/4/25.

All staff educated on 8/4/2025 regarding reg 92 Windows, how to identify and handle maintenance issues within the facility.

Moving forward:

[redacted], will take weekly walk throughs of the facility to monitor for proper compliance. [redacted] will be over seeing compliance and randomly auditing all rooms and floors of the facility for the next 6 months to maintain proper compliance.

92 - Windows (continued)

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

Implemented [redacted] - 10/08/2025)

103e - Left Overs

9. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At approximately 10:07 a.m. there was an unlabeled, undated plastic bag of cinnamon raison bread in the cupboard of the 2nd floor kitchenette.
At approximately 1:00 p.m. there was an unlabeled, undated bag of breakfast sausage links and bag of breadsticks in the freezer in the kitchen.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

"freezer"labels were purchased and put on unlabeled products, however they do NOT stick when placed on frozen foods. This admin and the dietary staff have agreed to keep the food in its original containers as much as possible, when we can't we will just keep putting the labels on as best we can. Ultimately it is this admins responsibility to ensure labels are on or products are in their original packages, it was n oversight as the kitchen staff knew what was in the packages that were not labeled and did not think about labeling them however now everything is labeled and will continue t be labeled. Ultimately it is again this admins responsibility to ensure it is done

8/4/25

Corrected at time of inspection.

All kitchenettes, kitchen and storage areas were audited on 6/30/25 and found to be in compliance.

[redacted] audited all kitchenettes, kitchen and storage areas on 8/2/25 and found them to all be in compliance.

All staff educated on 8/4/2025 regarding reg 103e Leftovers. How to identify and properly handle, label and store leftover food to preserve food safety in the facility.

103e - Left Overs (continued)

Moving Forward:

Kitchen staff have been provided labels for usage when leftover food is present. All staff are responsible for proper compliance. [redacted] will be over seeing compliance and randomly auditing all kitchenettes, kitchen and storage areas of the facility for the next 6 months to maintain proper compliance.

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

Implemented [redacted] - 10/08/2025)

103i - Outdated Food

10. Requirements

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

Description of Violation

At approximately 10:00 a.m. there was a 20 oz bottle of mayonnaise in the 3rd floor kitchenette refrigerator that expired on 3/12/25.
At approximately 10:05 a.m. there was a container of yogurt in the 2nd floor kitchenette refrigerator that expired on 6/24/25.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

Corrected at time of inspection, dietary and housekeeping will be responsible for checking the condiments in the kitchenettes to ensure there is nothing out dated, this admin will also check weekly also to ensure there is nothing outdated in the fridges Ultimately it is the responsibility of this admin to ensure it is done and nothing is outdated. Residents place stuff in the fridges without staff knowledge, again this admin, kitchen and housekeeping staff will be responsible to ensure this does not happen again Ultimately it is this admins responsibility to ensure it happens

8/4/25

Corrected at time of inspection.

All kitchenettes, kitchen and storage areas were audited on 6/30/25 and found

103i - Outdated Food (continued)

to be in compliance.

[redacted] ***audited all kitchenettes, kitchen and storage areas on 8/2/25 and found them to all be in compliance.***

All staff educated on 8/4/2025 regarding reg 103i Outdated food. How to identify and properly handle, label and store food to preserve food safety in the facility.

Moving Forward:

Night shift employees are now responsible for cleaning kitchenette refrigerators and cabinets, with a signature sheet for them to sign when cleaning is done. weekly. Kitchen staff have been provided same signature sheet to follow to maintain compliance in main kitchen and storage area. All staff are responsible for proper compliance. [redacted] ***will be over seeing compliance and randomly auditing all kitchenettes, kitchen and storage areas of the facility for the next 6 months to maintain proper compliance.***

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

Implemented [redacted] ***- 10/08/2025)***

105g - Lint Removal and Duct Cleaning

11. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

At approximately 9:30 a.m. there was a 1/16th of an inch accumulation of lint behind the dryer and on the dryer hose.

Plan of Correction ***Accept*** [redacted] ***/12/2025)***

Laundry and maintenance personnel will be responsible to check that daily and as needed to ensure there is no lint there. If there is it will be removed immediately. Ultimately it is the responsibility of this admin to ensure it is done to decrease the risk of potential fire risk Again it is this admins responsibility to ensure it is done

105g - Lint Removal and Duct Cleaning (continued)

8/4/25

Corrected at time of inspection.

Audit of facility laundry room has been completed and found to be in compliance as of 8/4/25.

All staff educated on 8/4/2025 regarding reg 105g Lint Removal and Duct Cleaning. How to identify, clean/empty/sweep and handle maintenance/laundry room issues within the facility.

Moving forward:

[redacted] ***will take weekly walk throughs of the facility laundry room to monitor and maintain for proper compliance. Signature sheet will be provided for lint removal and duct cleaning.*** [redacted] ***will be over seeing compliance and randomly auditing laundry room of the facility for the next 6 months to maintain proper compliance.***

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

Implemented [redacted] ***- 10/08/2025)***

121a - Unobstructed Egress

12. Requirements

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

Description of Violation

At approximately 9:40 a.m. a chair blocked the egress from the home's stairwell exit to the resident smoking area.

Plan of Correction ***Accept*** [redacted] ***- 08/12/2025)***

Was corrected at time of inspection,

All staff and residents were once again reminded tht that has to remain unblocked as t is an egress route,

121a - Unobstructed Egress (continued)

This admin has been checking daily and when I am not here the assistant admin will check to ensure it is clear. Ultimately it is the responsibility of this admin to ensure it remains clear

8/4/25

Corrected at time of inspection.

Audit of all stairways, hallways, doorways, passageways and egress routes have been completed and found to be in compliance as of 8/4/25.

All staff educated on 8/4/2025 regarding reg 121a Unobstructed Egress. How to identify, maintain and handle issues regarding stairways, hallways, doorways, passageways and egress routes within the facility.

Moving forward:

[redacted]***, will take weekly walk throughs of the facility stairways, hallways, doorways, passageways and egress routes within the facility to monitor and maintain for proper compliance. Signature sheet will be provided for walk thru.*** [redacted] ***will be over seeing compliance and randomly auditing laundry room of the facility for the next 6 months to maintain proper compliance.***

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

Implemented [redacted] ***- 10/08/2025)***

131f - Fire Extinguisher Inspection

13. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the kitchen had not been inspected since April 2023.
The fire extinguishers in the 1st floor lounge area and on the 2nd and 3rd floors near the stairwells had not been inspected since April 2024.

131f - Fire Extinguisher Inspection *(continued)*

Plan of Correction ***Accept [redacted] - 08/12/2025)***

The fire extinguisher in the kitchen was replaced the day after inspection. The other fire extinguishers were changed out the day of inspection. Owner will be notified yearly after Johnson Control does there checks and will be replaced immediately. Ultimately it is the responsibility of this adm to ensure this is done yearly
All have been replaced and will be checked monthly to ensure they are all good. Again this admin is ultimately responsible to ensure it is done

8/4/25

Corrected on 6/27/25, please see attached invoice and fire extinguisher report.

Audit of all fire extinguishers in facility has been completed and found to be in compliance as of 8/4/25.

All staff educated on 8/4/2025 regarding reg 131f Fire Extinguisher Inspection. How to identify, notify and handle issues regarding fire extinguishers within the facility.

Moving forward:

Fire Extinguisher list will be provided to the inspection company upon arrival at facility regarding location and placement to ensure none are missed and are properly inspected. [redacted] will take weekly walk throughs of the facility to monitor and maintain for proper compliance regarding fire extinguishers tags. [redacted] will be over seeing compliance and randomly auditing fire extinguishers tags for the next 6 months to maintain proper compliance.

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

Implemented [redacted] - 10/08/2025)

132c - Fire Drill Records

14. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

132c - Fire Drill Records *(continued)*

Description of Violation

The fire drill record for the drill conducted on 5/1/24 does not include the information that resident #2 did not evacuate during the fire drill held at 3:15 p.m.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

Resident will be evacuated for every fire drill, pictures will be taken to prove that it is done, (if allowed). Ultimately it is the responsibility of this adm to ensure [redacted] is up and evacuated to fire safe area, it will be done monthly
Again it is my responsibility as the admin to ensure this continues every fire drill

8/5/2025-

Fire drill record has been audited as of 8/5/25 and found to be in full compliance.

Office staff educated on 8/4/2025 regarding reg 132c Fire Drill Records. The importance of proper documentation of fire drill records along with the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Moving Forward:

Resident #2 will be moving to the first floor within the next 30 days. [redacted] will also be having a level of care evaluation done by her doctor and hospice which will then involve a family conference after all the information is gathered to verify, we are able to meet her needs where her current condition is.

[redacted] will be over seeing ongoing compliance and will be active in current and future plan for resident #2.

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

Implemented [redacted] - 10/08/2025)

132h - Designated Meeting Place

15. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 5/1/25 at 3:15 p.m. resident #2 did not evacuate to a designated meeting place away from the building or within a fire-safe area.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

Resident will be evacuated for every fire drill,
This adm will ensure it is done, pics will; be taken (if allowed) to prove that [redacted] was evacuated, Ultimately it is the responsibility of this adm to ensure it is done for [redacted] safety and well being
Again it it the responsibility of this admin to ensure it continues to occur

8/5/2025-

Residents and staff interviews on 8/5/25 by [redacted] have confirmed that Resident #2 has been evacuating for most recent fire drills and found to be in full compliance.

All staff educated on 8/4/2025 regarding reg 132h Designated Meeting Place. The importance of residents evacuating to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Moving Forward:

Resident #2 has been evacuated for the most recent fire drills; [redacted] will be moving to the first floor within the next 30 days. [redacted] will also be having a level of care evaluation done by [redacted]r doctor and hospice which will then involve a family conference after all the information is gathered to verify, we are able to meet [redacted] needs where [redacted] current condition is.

[redacted] will be over seeing ongoing compliance and will be active in current and future plan for resident #2.

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

Implemented [redacted] - 10/08/2025)

144c1 - Smoking Area Guidelines

16. Requirements

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

Description of Violation

At approximately 9:34 a.m. there were cigarette butts on the ground surrounding the staff smoking area.
At approximately 9:39 a.m. there were cigarette butts on the ground in the resident smoking area and there were cigarette butts found in a planter mixed with dried pine needles.
Repeated violation 10/10/24.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

Both areas were cleaned of all cigarette butts and ashes from the areas. The potted plants were removed from the patio area as the smoking residents have been told so many times not to use them for that purpose. Areas have been checked daily now to ensure that they are free of cigarette butts by this adim. When I am not here the assistant adm will check to ensure there are no butts or ashes. Ultimately it is this admins responsibility to ensure that the area remains clean and cigarette butt free
The area is monitored daily to ensure it stays clean, the smokers are reminded daily to smoke in designated area and use the receptacle

8/4/25

Corrected at time of inspection, potted plants removed.

Audit of all smoking sections were done and have been found to be in compliance as of 8/4/25.

All staff educated on 8/4/2025 regarding reg 144c1 Smoking Area Guidelines. How to identify, maintain, handle and preserve safety regarding smoking sections of the facility.

Moving forward:

Staff and Resident smoking sections will be audited by staff to monitor and ensure compliance regarding location and placement of extinguished cigarette butts. [redacted], will take weekly walk throughs of the facilities smoking sections to monitor and maintain for proper compliance regarding location and placement of extinguished cigarette butts. [redacted]

144c1 - Smoking Area Guidelines (continued)

[redacted] ***will be over seeing compliance and randomly auditing smoking sections for the next 6 months to maintain proper compliance.***

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

Implemented [redacted] - 10/08/2025)

144c2 - Smoking Area Distance

17. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

There was a chair less than 2 feet from the stairwell exit door with a 6-inch pile of cigarette ashes, indicating smoking outside the designated smoking area and less than 2 feet from an entrance door was occurring.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

Was corrected on inspection. Chair was removed ashes were cleaned up, once again residents were told to smoke closer to the receptacles provided. This adm has been talking and checking to residents daily. Ultimately it is this adm responsibility to ensure they comply, in my absence the assistant adm will ensure they comply. The residents place the chairs there in inclement weather, again they are repeatedly tokld they cannot do that hence the daily checks

8/4/25

Corrected at time of inspection, chair was removed, and ashes were cleaned.

Audit of all smoking sections were done and have been found to be in compliance as of 8/4/25.

Residents that utilize the smoking section were educated on 8/4/25 regarding reg 144c2 Smoking Area Distance. How to identify, maintain, handle and preserve safety regarding safe smoking section distance.

All staff educated on 8/4/2025 regarding reg 144c2 Smoking Area Distance How to identify, maintain, handle and preserve safety regarding safe smoking section distance.

144c2 - Smoking Area Distance (continued)

Moving forward:

Staff and Resident smoking sections will be audited by staff to monitor and ensure compliance regarding safe smoking distance practices and proper cigarette butt extinguishing practices. [redacted] for [redacted], will take weekly walk throughs of the facilities smoking sections to monitor and maintain for proper compliance regarding safe smoking distance practices and proper cigarette butt extinguishing practices. I, [redacted] will be over seeing compliance and randomly auditing smoking sections for the next 6 months to maintain proper ongoing compliance.

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

Implemented [redacted] - 10/08/2025)

183e - Storing Medications

18. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

The Albuterol Sulfate inhaler found in the medication cart for resident #3 expired February 2025.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

Resident 3 Albuterol was replaced that day when the pharmacy brought to us and placed in cart, Assistant Adm and Med tech supervisor and this adm will check carts weekly to ensure all meds are in the carts and not expired, if expired will reorder immediately from pharmacy to ensure continuity of medication. Ultimately it is the responsibility of this adm to ensure meds are not exp;ired and in the carts as ordered, This will be checked weekly by asst adm and med tech supervisor. Ultimately it is this adm responsibility to ensure it is done

8/4/25

Corrected at time of inspection. Removed from cart and new one ordered/arrived from Newhards Pharmacy on 6/26/25

Audit of all facility meds carts by [redacted] was done on 8/2/25 and found to be in compliance

183e - Storing Medications (continued)

All med techs educated on 8/4/2025 regarding reg 183e Storing Medications. How to identify and handle proper storage procedures and practices regarding prescription medications, OTC medications and CAM within facility med room.

Moving forward:

Medications carts will be audited weekly by [redacted] to monitor and maintain proper compliance. Signature sheet will be provided for weekly audits. [redacted] will be over seeing compliance and randomly auditing med room. medication cart or diabetic supplies for the next 6 months to maintain proper ongoing compliance.

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

Implemented [redacted] - 10/08/2025)

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:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for resident #4's Insulin Aspart does not include the sliding scale order on the pharmacy label.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

This adm spoke with the pharmacy, They stated that there is no way they can put the sliding scales on the insulin pens, there is no room. When the accu check number is inputted the sliding scale will come up; and tell us how much to give. we have never had the sliding scale on the pen or vial, If you have questions concerning this please call Newhard Pharmacy

We came up with a way to do this to since the pharmacy said they couldn't help us. This system will continue for the sliding scale for the residents and any new ones that are admitted. Ultimately it is this admins responsibility to

184a - Resident's Meds Labeled (continued)

ensure it is done and continues

8/4/25

Corrected on 6/27/25 by assistant to admin [redacted]

Audit of all facility meds carts/ sliding scale by [redacted] was done on 8/2/25 and found to be in compliance.

All med techs educated on 8/4/2025 regarding reg 184a Resident's Meds Labeled. How to identify and handle proper resident medication labels within the facility med room.

Moving forward:

Spoke to [redacted] Newhards Pharmacy, all resident orders that contain sliding scale insulin will have additional labels attached to pens or vials for sliding scale instructions. Medications carts/Diabetic orders will be audited weekly by [redacted] and [redacted] to monitor and maintain proper compliance. Signature sheet will be provided for weekly audits. [redacted] will be over seeing compliance and randomly auditing med room, medication cart or diabetic supplies for the next 6 months to maintain proper ongoing compliance.

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

Implemented ([redacted] - 10/08/2025)

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 #5 has an order for Meclinzine 25mg, one tablet every 8 hours as needed for dizziness. The medication was not available in the medication cart to be administered if needed. Repeat Violation: 10/10/24

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept [redacted] 08/12/2025)***

The meclizine was ordered and put in the cart the day of inspection. The assist adm, med tech supervisor and this adm will check carts weekly to ensure all meds are in the cart. Ultimately it is this adm responsibility to ensure all meds are in the cart as ordered
Again ultimately it is the responsibility of this admin to ensure this is done

8/4/25

Corrected at time of inspection. New card was ordered/arrived from Newhards Pharmacy on 6/26/25

Audit of all facility meds carts by [redacted] was done on 8/2/25 and found to be in compliance.

All med techs educated on 8/4/2025 regarding reg 185a Implement Storage Procedures. How to identify and handle proper safe storage, access, security, distribution and use of medications and medical equipment.

Moving forward:

Medications carts will be audited weekly by [redacted] to [redacted] to monitor and maintain proper compliance. Signature sheet will be provided for weekly audits. [redacted] will be over seeing compliance and randomly auditing med room, medication cart or diabetic supplies for the next 6 months to maintain proper ongoing compliance.

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

Not Implemented [redacted] - 10/08/2025)

187b - Date/Time of Medication Admin.

21. Requirements

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

Description of Violation

Resident #4 has an order for Dexamethasone 4mg, three tablets every 2 weeks on Thursdays with breakfast. From 6/5/25 through 6/14/25 and 6/21/25 through 6/26/25 the medication was initialed as administered daily at 8:00

187b - Date/Time of Medication Admin. (continued)

a.m. The medication should only have been initialed as administered on the MAR on 6/5/25 and 6/19/25 when it was actually administered.
Repeated violation 10/10/24.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

Spoke with the pharmacy, the med was set right on the MARs. This admin spoke with med techs on the importance of reading the MARs more carefully and they see something wrong to let the assist adm know right away to let the pharmacy know. Ultimately it is the responsibility of the adm to ensure this is done and done correctly, This will be checked weekly by asst admin and med tech supervisor and ultimately it is this adins responsibility that it will be done

8/4/25

[redacted] spoke with Newhard Pharmacy and made them aware of the error. Newhards corrected the issue within the QuickMar system day of inspection 6/26/25.

Audit of all facility meds carts and compared to MARs in Quickmar by [redacted] was done on 8/2/25 and found to be in compliance.

All med techs educated on 8/4/2025 regarding reg 187b Date/Time of Medication Admin. How to identify and handle proper recording of medication administration at the time the medication is administered.

Moving forward:

Medications carts will be audited weekly by [redacted] to [redacted] to monitor and maintain proper compliance. Signature sheet will be provided for weekly audits. [redacted] will be over seeing compliance and randomly auditing med room, medication cart and MARs for the next 6 months to maintain proper ongoing compliance.

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

Not Implemented [redacted] - 10/08/2025)

187d - Follow Prescriber's Orders

22. Requirements

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

Description of Violation

Resident #6 has an order for Artificial Tears Drops, one drop into both eyes 4 times daily. On 6/24/25 at 4:00 p.m. the drops were not administered.
Resident #6 has an order for Tamsulosin HCL .4mg, one capsule once daily at 5:00 p.m. On 6/24/25 at 5:00 p.m. the medication was not administered.
Repeated violation 10/10/24.

Plan of Correction ***Accept [redacted] - 08/12/2025)***

Meds were given as indicated by the med packaging however it was not signed for. This admin spoke to all med techs on the importance of reading the mars and ensuring they are signed completely before moving on to the next persons med pass. Ultimately it is the responsibility of this admin to ensure it is done correctly and no blanks are on the MARs. An inservice was given to all med techs to ensure they understand the importance of signing the MARs correctly

8/4/25

Interview with resident #6 and review of med packaging shows both medications were admistered.

Audit of all facility MARs by [redacted] was done on 8/2/25 and found to be in compliance.

All med techs educated on 8/4/2025 regarding reg 187d Follow Prescriber's Orders. How to identify and follow the directions of the prescriber. Also educated on QuickMar dashboard.

Moving forward:

All medtechs will check QuickMar dashboard during change of shift to verify medication has been signed out properly.

Medications carts and MARs will be audited weekly by [redacted] to monitor and maintain proper compliance. Signature sheet will be provided for weekly audits. [redacted] will be over seeing compliance and randomly auditing med room, medication cart

187d - Follow Prescriber's Orders (continued)

and MARs for the next 6 months to maintain proper ongoing compliance.

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

Implemented (- 10/08/2025)

225c - Additional Assessment

23. Requirements

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

Description of Violation

Resident #7 requires a mechanical soft diet. The resident's assessment dated 25 does not include the need for a mechanical soft diet.

Plan of Correction ***Accept - 08/12/2025)***

An addendum was done for Resident #6. All changes for the residents will either have a new RASP or an addendum to reflect those changes. Ultimately it is the admins responsibility to ensure that this is done for any and all changes. We have not had any changes in any of the residents since inspection but if we ever have changes an addendum or new RASP will be done. Ultimately it is this admins responsibility to ensure it is done

8/4/25

Addendum was added to RASP for resident #6 on 6/27/25.

Audit of all DME's for Additional Assessment was done by on 8/3/25 and found to be in compliance.

Office staff was educated on 8/4/2025 regarding reg 225c Additional Assessment. The importance of documentation if the condition of the resident significantly changes prior to the annual assessment.

Moving forward:

Office staff will be more diligent with maintain proper records. Additional assessment will be listed in in RASP and in informational orders in Quickmar. will double check, monitor and maintain proper compliance after RASP is completed by admin.

225c - Additional Assessment (continued)

[redacted] ***will be over seeing compliance and randomly auditing DME's and RASP for the next 6 months to maintain proper ongoing compliance.***

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

Implemented [redacted] *- 10/08/2025)*