



Pennsylvania Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 5, 2025

Family Cares LLC
[REDACTED]

RE: Family Cares Personal Care Home
101 South Broad Street
New Freedom, PA 17349
License #: 337941

Dear Family Cares LLC:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing’s (Department) licensing inspections on July 15, 2025, July 16, 2025, July 17, 2025, October 8, 2025 and October 9, 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 #337940 dated December 19, 2024 until December 19, 2025, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2);(3);(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from DECEMBER 5, 2025 to JUNE 5, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with **Choose an item.** must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
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25(a)	III	12	\$3	\$36	15 calendar days from mailing date of this letter
26(a)	III	12	\$3	\$36	15 calendar days from mailing date of this letter
60(a)	II	12	\$5	\$60	5 calendar days from mailing date of this letter
107(d)	III	12	\$3	\$36	15 calendar days from mailing date of this letter
127(a)	III	12	\$3	\$36	15 calendar days from mailing date of this letter
132(b)	II	12	\$5	\$60	5 calendar days from mailing date of this letter
184(b)	III	12	\$3	\$36	15 calendar days from mailing date of this letter
225(a)	III	12	\$3	\$36	15 calendar days from mailing date of this letter
227(a)	III	12	\$3	\$36	15 calendar days from mailing date of this letter

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

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

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

[REDACTED]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
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
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]

Enclosure
License

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

Facility Information

Name: *FAMILY CARES PERSONAL CARE HOME* License #: *33794* License Expiration: *12/19/2025*
Address: *101 SOUTH BROAD STREET, NEW FREEDOM, PA 17349*
County: *YORK* Region: *CENTRAL*

Administrator

Name: [REDACTED]

Legal Entity

Name: *FAMILY CARES LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *11/01/2004* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *15* Waking Staff: *11*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *07/22/2025*

Inspection Dates and Department Representative

07/15/2025 - On-Site: [REDACTED]
07/16/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *17* Residents Served: *12*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *12* Are 60 Years of Age or Older: *12*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *3* Have Physical Disability: *2*

Inspections / Reviews

07/15/2025 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *08/29/2025*

09/19/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *09/06/2025*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *10/01/2025*

10/28/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *10/01/2025*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 7/15/25, the home's current violation report, dated 7/9/24, was posted in a conspicuous and public place in the home, however it did not include the home's plan of correction. The home's licensing inspection summaries, dated 11/21/24 and 12/17/24, were not posted in a conspicuous and public place in the home.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

effective immediately the administrator will print the plan of correction and summaries and file them in a 3 ring 1 inch notebook. the administrator will print a note stating, "the current license summary and plan of correction is available upon request" and post it in the hall with all of the other required documents. the administrator will train staff immediately that the current license and plan of correction is located in a 3ring 1 inch notebook inside of the hallway's drawer. all visitors and residents will at all times be welcomed to review the license summaries and plan of correction.

during the upcoming staff meeting on 9/8/25, the administrator will train and inform all staff about the importance of being vigilant of the summaries and plan of correction, to make sure they are always available and in a conspicuous place.

moving forward and ongoing the administrator will remind all staff of the importance of making sure the plan of correction and summaries are always available when requested. staff will be responsible to make sure the plan of correction is safely kept, legible, and in good condition. at any time, the summary or plan of corrections were to become demanded, the staff is responsible for notifying the administrator via our communication book. the administrator will be sure to check the communication book daily at the beginning of the shift to ensure there are no notes pertaining to the license or/and plan of correction is missing or/and demanded.

the administrator will be responsible for printing and filing the correction and summaries in a timely manner, within one business of receipt and making sure they are posted as regulated

(Directed)

- The plan of corrections and licensing inspection summaries, dated 7/9/24, 11/21/24 and 12/17/24 will be printed and filed by the Administrator in a 3-ring notebook and placed in or on a table that is accessible to all residents and visitors by 9/30/25. If the notebook is not immediately visible, a sign will be posted with directions on how to locate the binder without the assistance of staff.
- The Administrator will provide education to all staff in the home on the location of the binder and the requirements of 2600.3(c) by 9/30/25.
- Beginning no later than 9/30/25, the Administrator will complete quarterly audits on the contents of the notebook to ensure continued compliance with 2600.3(c).
- Documentation of staff education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/22/2025)

5a1 - DHS Access

2. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On 7/15/25, an agent of the Department was not provided access to July 2025 Medication Administration Records (MARs) for residents #1, #2, #3, and #4. Resident MARs were not provided until 7/16/25.

On 7/15/25 at 10:30 AM, the administrator designee, staff member A, was the only staff member present in the home and did not provide access to the locked basement of the home or the locked door in the medication room. On 7/16/25 at 12:41 PM, agents of the Department requested access to the home's basement. The home's administrator, staff member B, refused to allow the agents of the Department into multiple locked doors located in the home's basement.

On 7/15/25, an agent of the Department requested access to the home's narcotic medication storage drawer in the home's medication cart; however, was not granted access until 7/16/25.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

on 7/15/25 the administrator was leaving the home to go [REDACTED], moving fast, the administrator unconsciously took the keys to the doors of the file cabinet and the basement door. upon return the administrator allowed the agent access to doors as well as the file cabinet which were storing the MARs.

the narcotic drawer key was located in the top of the medication cart; the administrator is unaware of why the agent did not utilize the key to access the narcotic drawer. staff did allow access to both medication carts and was informed of the narcotic key's location. the staff reported to have had opened the medication carts for the agents to allow them to investigate the carts.

moving forward, effective immediately, the administrator will inform all PCAs during the upcoming staff meeting on 9/8/25 to allow state agents full access to all rooms and areas of the home that pertain to the business. the administrator will train all new hires of the importance of allowing state agents access to areas of the home that pertain to the business.

the locked door by the medication area is currently being renovated and was locked to protect the safety of the residents as well as staff.

upon completion of the room, estimated to be completed on 9/30/2025, the administrator shall open the doors for the residents and staff to access. until then, effective immediately, the administrator has unlocked the door and has made staff and residents aware of the construction and informed everyone not to enter the room until completed. effective immediately, all doors, pertaining to the business, shall remain unlocked at all times. the staff is responsible for walking around the home at least one time during their assigned shift, to ensure all doors are unlocked. staff are to immediately report any locked doors to the administrator via text or/and our communication book. upon report of a locked door, the administrator will immediately within one business day, unlock the door or area of the home that pertains to the business

5a1 - DHS Access (continued)

(Directed)

- The administrator and all staff in the home will be educated on 2600.5(a)(1) by 9/30/25. Education will include providing access to all areas within the licensed setting including all areas of the basement and locked rooms.
- The administrator will make spare copies of each key needed to access areas of the home to ensure staff have access to locked areas when the administrator is not available on-site. Additional education on where keys are located within the home will be provided to all staff so immediate access can be granted to Agents of the Department upon request. This step will be completed no later than 9/30/25.
- The locked door by the medication area is currently being renovated and was locked to protect the safety of the residents as well as staff. Effective immediately, the administrator has unlocked the door and has made staff and residents aware of the construction and informed everyone not to enter the room until completed.
- Beginning no later than 9/30/25, the administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to the Department. This includes all areas of the basement.

Directed Completion Date: 09/30/2025

Not Implemented (█) - 10/22/2025)

5a3 - Long Term Care Ombudsman Access

3. Requirements

2600.

- 5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
 3. Representatives of the Long-Term Care Ombudsman Program.

Description of Violation

On 7/16/25 at approximately 9:50 AM, York County Long Term Care Ombudsman requested access to the home and to meet with residents. Staff member A did not permit access until after 10:00 AM during the home's visiting hours.

Plan of Correction

Directed (█) - 09/17/2025)

moving forward, effective immediately, the administrator will inform all PCAs and volunteers during the upcoming staff meeting on 9/8/25 to allow long term ombudsman access to visit the residents of the home at any time. the administrator will train all new hires on the importance of allowing the ombudsman access to areas of the home that pertain to the business.

since the inspection, the administrator has informed staff member A the difference between a visitor and state agents or/and ombudsman access to the home; they do not have to wait for the visiting hours to begin to gain access to the home. the administrator will share this information during the upcoming staff meeting on 9/8/2025 as well as during all new hires' orientation.

(Directed)

- The administrator will inform all PCAs and volunteers during the upcoming staff meeting on 9/8/25 to allow long term ombudsman access to visit the residents of the home at any time.
- Beginning no later than 9/30/25, the administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to Representatives of the Long-Term Care Ombudsman Program.

5a3 - Long Term Care Ombudsman Access (continued)

- Documentation of completed education will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/22/2025)

17 - Record Confidentiality**4. Requirements**

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 7/15/25 at 9:15 AM and again at 10:22 AM, the following resident record and information was unlocked, unattended and accessible in the staff office.

- July 2025 medication administration records (MARs) for residents #5 and #6.
- June 2025 MARs for residents #2, #4, and #7.
- Medical evaluations for residents #1, #2, and #3 .

On 7/15/25 at 10:40 AM, resident #8's medication order for Latanoprost .00% eye drop refills was unlocked, unattended, and accessible in the medication area.

Plan of Correction

Directed [REDACTED] R - 09/17/2025)

the office door was locked until the administrator unlocked the door for the inspector to have somewhere to seat and conduct [REDACTED] inspection. the administrator forgot to unlock the file cabinet which had the remaining residents' information. therefore, in the grand scheme of things, the residents' information is always locked; the administrator made the office accessible for the inspector, which in turn made the files "unlocked, and accessible"

the refill order is literally a small sticky barcode that is faxed to [REDACTED] pharmacy. it was on the medication cart in an area only the staff accesses. however, effectively immediately, the administrator will immediately take the refill order from the bottle and walk to the locked office and fax the refill orders to [REDACTED] pharmacy. once faxed and receipt is confirmed, the administrator will discard the order. the order does not provide health information, other than the name of the resident and the medication, therefore the administrator will discard it in the office's trash can

All MARs are stored away in the MAR book. effective immediately the administrator will ensure to put back all MARs directly after using them. the administrator will be responsible to ensure that MARs are stored in the book daily. each day the administrator will check the book at night to ensure proper storage of the book, filing of medical information, and to ensure completion of medication administration. if at any time the book isn't stored properly, medication administration is incomplete or if medical information isn't filed properly, the administrator will confront the responsible staff member within one business day and informed them of the needed correction. the administrator will notify the responsible staff via text or our communication book. staff will have one business day to correct the mistake unless the correction can be made by the administrator. the administrator will follow up with the correction after the one business day. the administrator will check daily for the next 30 days to ensure this task becomes habitual for staff as well as for the administrator, all residents' information will continue to be locked away in the file cabinet in the office. a spare key will be given

17 - Record Confidentiality (continued)

to staff to allow state agents, ombudsman, designees and/or residents access to residents' information upon request. the administrator will discuss the importance of keeping all residents' information confident at all times during the upcoming staff meeting on 9/8/2025 and during all new hire orientation. the administrator will reiterate this information annually at the beginning of July to all staff and volunteers, if any.

(Directed)

In addition to the above plan of correction,

- The administrator will provide education to all staff on 2600.17 by 9/30/25-education will include ensuring the office door storing resident information remain locked when it is unattended.*
- Beginning no later than 9/30/25, the administrator will complete daily audits of the home to ensure resident information is kept confidential and inaccessible to others when left unattended.*
- Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: 09/30/2025

Not Implemented  **- 10/22/2025)**

25a - Written Contract and Review

6. Requirements

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #2, admitted [REDACTED]/25, and resident #4, admitted [REDACTED]/25, did not have a resident-home contract completed.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

both had contracts; however the inspector missed the contract in the residents' chart.

however, effective immediately, the administrator will file residents' information in notebooks with dividers so that all information is easily accessible.

the administrator will buy 3 ring 3-inch notebooks for all incoming residents as well as several dividers to organize their information. the notebook will contain a table of contents to easily guide the reader to the needed information. the administrator will also update the "state inspection" book that includes pertinent information that the inspectors regularly request during inspections, such as current DMEs, RASP, resident home contracts, prescreen forms and resident demographics. this notebook will be organized as well and easily accessible for state inspectors, residents, ombudsman and/or designees while remaining in a locked area.

the administrator will make sure to discuss and sign the resident contract on the day of admission. despite what's going on, the administrator will ensure this form is discussed and signed by making that the first thing to do upon arrival. the administrator will be moving forward, effective immediately, will inform the resident and designee prior to the admission date that the first thing to do on admission day is to discuss review and sign the resident contract. the administrator will not allow any unpacking or moving in until the resident contract has been discussed, signed, copies made and filed away in the resident chart. once this and payment is completed, the administrator will then assist with the resident moving in.

the administrator will include this information in the email sent prior to admission reiterating the importance of discussing and signing the contract prior to moving in

25a - Written Contract and Review (continued)

(Directed)

- The administrator will review contracts with residents #2 and #4 by 9/30/25 and file the signed contracts in the residents' records.
- The administrator will complete an initial audit of all other resident contracts to ensure they are signed and filed in the resident record by 9/30/25.
- Beginning no later than 9/30/25, the administrator will ensure all new admissions are reviewed and signed by the resident moving into the home by completing an audit of each new contract within 24 hours of the resident residing in the home.
- Documentation of completed contracts and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/22/2025)

25b - Contract Signatures

7. Requirements

2600.

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

Description of Violation

The following resident-home contracts were not signed by the residents:

- Resident #2's contract, dated [REDACTED] 25.
- Resident #5's contract, dated [REDACTED] /25.
- Resident #8's contract, dated [REDACTED] /25.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

the administrator obtained signatures from these resident's [REDACTED] therefore the administrator believed this was suffice. Because the administrator did not have accurate information, the administrator will be sure to have each resident sign their resident home contract as soon as possible. effective immediately, the administrator will review all current contracts to make sure all residents, as well as their [REDACTED], have signed their contracts. the administrator will complete this by 9/30/2025. moving forward, the administrator will also make sure during admission that both parties, if applicable, sign the contracts before the resident moves in. the administrator will conduct annual checks to make sure all contracts are signed. the administrator will begin these annual checks in June of each year

(Directed)

- The administrator will receive education on 2600.25(b) by 9/30/25.
- The administrator will review contracts with residents #2, #5, and #8 and obtain necessary signatures by 9/30/25.
- An initial audit of all other resident contracts will be completed by the administrator by 9/30/25.
- Beginning no later than 9/30/25, the administrator will ensure all new admissions are reviewed and signed by the resident moving into the home by completing an audit of each new contract within 24 hours of the resident residing in the home.
- Documentation of education, completed contracts and audits will be kept by the home and available for

25b - Contract Signatures (continued)

review by the Department.

Directed Completion Date: 09/30/2025

Implemented [REDACTED] - 10/22/2025)

26a - Quality Management Plan**8. Requirements**

2600.

26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home did not have a quality management plan or review in the last year.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

the administrator has a quality management plan. each day the inspector was there, i was dealing with all types of issues, two [REDACTED], and my [REDACTED], therefore i left the office open for the inspector to find these things. i apologize that the quality management plan was not discovered but i will submit them in sans write for review

(Directed)

- The administrator will review and update the home's quality management plan policy and procedure by 9/30/25.*
- A quality management plan review be completed by the administrator no later than 9/30/25 and filed in the home's record.*
- Beginning no later than 9/30/25, the administrator will complete a quarterly audit of the home's quality management plan to ensure timely implementation and continued compliance with 2600.26(a).*
- Documentation of completed quality management plan and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/22/2025)

42e - Telephone Access**9. Requirements**

2600.

42.e. A resident shall have access to a telephone in the home to make calls in privacy. Nontoll calls shall be without charge to the resident.

Description of Violation

On [REDACTED] 25, resident #2 contacted the local police. Staff member B removed the common telephone from the home so resident #2 could not make telephone calls.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

this is not true information

the administrator never took the house phone from the home nor a resident.

42e - Telephone Access (continued)

(Directed)

- *The administrator will receive education on 2600.42(e) by 9/30/25 to include the following topics: a telephone must be available to residents at all times of the day or night, the phone must be arranged so that residents can make private calls without being heard by staff or other residents, a home may not require residents to ask for the telephone or ask permission to use the telephone and homes may not screen incoming calls to residents.*
- *All staff in the home will be educated by the administrator on 2600.42(e) by 9/30/25 to include the following topics: a telephone must be available to residents at all times of the day or night, the phone must be arranged so that residents can make private calls without being heard by staff or other residents, a home may not require residents to ask for the telephone or ask permission to use the telephone and homes may not screen incoming calls to residents.*
- *Beginning no later than 9/30/25, the administrator or designee will complete an audit per shift to ensure the home telephones remain accessible to residents at all times of the day or night and does not require residents to ask for the telephone or permission to use the telephone.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/22/2025)

42p - Restraints

11. Requirements

2600.

42.p. A resident shall be free from restraints.

Description of Violation

Resident #1's bed was affixed with bilateral, half-rails that raise and lock in place when in use. Staff member A reported the rails are in place to prevent resident #1 from getting out of ■■■ bed. The home does not have physician's orders for use of the rails and resident #1 is unable to raise and lower the devices independently.

Plan of Correction**Directed ■■■ (09/17/2025)**

effective immediately, the administrator will request an order for bedrails for resident 1. resident 1 is capable of raising and lowering the bed devices independently. ■■■ also can self-propel ■■■ in the wheelchair, as the inspector observed. the resident uses the rails for a peace of mind while in the bed because ■■■ is afraid of falling out of bed at night. ■■■ can hold on to the rails to assist with rolling from side to side. they are in no way used as restraints. however, the administrator has requested a PCP order to have the bed rails on ■■■ hospital bed. moving forward effective immediately, the administrator will gather in-depth information for each new resident prior to admission to know if a hospital bed is necessary and if it is, the administrator will request a PCP order for bed rails, just in case the resident wishes to utilize them while in bed as resident 1 likes to. the administrator will follow up with the PCP order weekly on Thursdays until it's received. these follow up calls will begin Thursday 9/4. the administrator will be responsible for making sure any and all residents that use a hospital bed will have a PCP order prior to usage. moving forward, the administrator will also be responsible to make sure a PCP order is obtained prior to usage of any types of "restraints"

(Directed)

- *Resident #1's bed rails will be removed by 9/30/25.*

42p - Restraints (continued)

- *If the resident wishes to have a bed mobility device, the administrator will assess the resident's needs for a safer alternative means to provide the same benefits as bedrails with minimal risk, including: beds that can be raised or lowered to the floor, alternative assistive devices, such as enablers, grip handles, transfer handles, trapeze bars and halo safety rings. Resident #1's assessment and support plan will be updated to reflect any changes or use of bedside enabler devices by 9/30/25.*
- *The administrator and staff will receive education on the use of bed rails in the home by 9/30/25 as identified in the 2600 Regulatory Compliance Guide.*
- *Documentation of education and updated resident records will be kept by the home and available for review by the Department.*

Directed Completion Date: 09/30/2025

Implemented [redacted] - 10/22/2025)

42r - Visitation

12. Requirements

2600.

42.r. A resident has the right to receive visitors for a minimum of 12 hours daily, 7 days per week.

Description of Violation

The home's visiting hours are 10:00 AM-8:00 PM daily, permitting only 10 hours.

Plan of Correction

Directed [redacted] - 09/17/2025)

effective immediately, the administrator will begin to revise the resident home contract to indicate the new visiting hours, which are 9am-9pm. the administrator will inform all residents of the new visiting hours and will post the visiting hours on the home's door. the administrator is responsible for informing all residents, staff and family members of the new visiting hours. the administrator will contact all family members via email within 30 days to inform them of the change to the visiting hours. the administrator will include the visiting hour change topic in the next monthly resident council meeting on 9/5/2025. the administrator will inform staff of the visiting hours effective immediately as well as discuss it during the next staff meeting on 9/8/2025
the administrator will revise the contract to reflect the new visiting hours prior to admission as well as other corrections that are needed such as the burial arrangements and return/leave stipulations.
the administrator will pause all admissions until the contract has been revised. the contract will be discussed in its entirety to all new residents. the administrator wishes to resume admissions effective October 1 2025
the contract will be revised by 9/30/2025

(Directed)

- *The administrator will revise the visiting hours to be from 9:00 AM until 9:00 PM daily by 9/30/25.*
- *The administrator will provide education to all residents and staff members of the new visiting hours by 9/30/25.*
- *The administrator will contact all family members, as applicable, via email by 9/30/25 to inform the contacts of the revised visiting hours.*
- *Resident contracts, home postings and home rules will be updated to reflect the new visiting hours by 9/30/25.*
- *All notifications, education and updated rules, contracts and postings will be kept by the home and available for review by the Department.*

42r - Visitation (continued)

Directed Completion Date: 09/30/2025

Implemented [REDACTED] - 10/22/2025)

42s - Privacy

13. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

Staff member B, the home's Administrator, took resident #5's personal cell phone on [REDACTED]/25 due to the resident contacting 911. Staff member B did not return the personal cell phone to resident #5 until [REDACTED]/25.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

the administrator immediately returned the cell phone to the resident once [REDACTED] was told that removing the cell phone was a violation. the administrator also informed the resident's [REDACTED] that the administrator had to return the cell phone to the resident; despite [REDACTED] request for the administrator to remove the cell phone from the resident. the administrator was not aware of violating any rights therefore apologized to the resident and the family for not being informing of this rule.

the administrator will also inform all staff of such acts that constituent as a resident's rights violation effective immediately and will be discussed during the staff meeting on 9/4/2025 and during all new hire orientation. all staff will continue to be required to read the resident rights form and sign and date it. the form will be stored in the staff's chart. the administrator also will review the residents rights form to familiarize [REDACTED] more with all residents' rights

(Directed)

- The administrator will receive education on 2600.42(s) pertaining to privacy of possessions as defined in the 2600 Regulatory Compliance Guide by 9/30/25.
- The administrator will provide education to all staff on 2600.42(s) by 9/30/25.
- Beginning no later than 9/30/25, the administrator will interview at least 2 residents in the home each week to ensure the resident's right to privacy of self and possessions were maintained.
- Documentation of education and resident interviews will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/22/2025)

51 - Criminal Background Check

14. Requirements

51 - Criminal Background Check (continued)

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 member C, hired on [REDACTED] 25, has not resided in Pennsylvania within the last two years. A Federal Bureau of Investigation background check was not completed.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

staff member c submitted a criminal background check [REDACTED] and the administrator completed a PA criminal background check for staff member c. the administrator will request assistance to fully understand how to obtain a federal criminal background check for any staff that does not reside in PA for the last two years and all applicants moving forward. once the administrator obtains this information, federal criminal background checks will be conducted on all staff members. the administrator will complete these checks within 30 days. staff member c is no longer a staff member effective 5/2025, as reported to the inspectors.

the administrator will be responsible for conducting all PA and federal background checks unless the applicant resides in another state. if the applicant resides outside of PA, the applicant will be responsible for obtaining their state's criminal background check and submitting it to the administrator. the administrator will not hire nor begin orientation until both background checks have been completed and reviewed by the administrator.

(Directed)

- Staff member C is no longer an employee of the home, effective [REDACTED] 2025.
- The administrator will receive education on Criminal Background Checks and the Older Adult Protective Services Act by 9/30/25-educational materials may include information identified in the 2600 Regulatory Compliance Guide under Issues and Frequently Occurring Situations.
- The administrator will complete an audit of all current staff who work in the home to identify any additional staff who have not resided in Pennsylvania in the past two years and complete a Federal Bureau of Investigation background check, as necessary, by 9/30/25.
- Beginning no later than 9/30/25, all newly hired staff who have not resided in the state of Pennsylvania for 2 years or who currently reside outside of Pennsylvania, will have a Federal Bureau of Investigation background check completed on or before the first day of work.
- Beginning 9/30/25, the administrator will complete an audit of all newly hired staff background checks within 24 hours of the staff member's first day of work to ensure all employees have a Pennsylvania State Police Criminal Background Check as well as a report of federal criminal history record information from the Federal Bureau of Investigation, as applicable.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/22/2025)

60a - Staff/Support Plan

15. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident’s assessment and support plan.

Description of Violation

Staff member D, who has not completed the medication administration training, worked alone in the home from 11:00 PM to 7:00 AM on 7/1/25, 7/2/25, 7/8/25, 7/9/25, 7/14/25, 7/15/25, and 7/16/25, There are no scheduled medications at the home during this time; however, the following residents have medications scheduled pro re nata (PRN):

Resident #2: Albuterol HFA 90mcg as needed for wheezing, Trazodone 100mg as needed for insomnia

Resident #7: Albuterol Sul HFA 90 MCG as needed for wheezing or shortness of breath, Cetirizine 10mg as needed for allergies, Ondansetron ODT 4mg as needed for nausea or vomiting

Resident #8: Acetaminophen 650mg as needed for mild pain, Ibuprofen 400mg as needed for moderate pain, fever or headaches, Loperamide 2mg as needed for Diarrhea.

Repeated Violation - 11/21/24, 7/9/24, et al

Plan of Correction

Directed [REDACTED] - 09/17/2025)

the administrator informed other inspectors during other inspections that staff D and staff B work together at night, staff D is awake, and staff B is not always awake during these hours. because another medication trained staff is always present with staff D, the administrator does not recall being violated for this. however, because the administrator has been cited, the administrator has requested staff D to become med trained. training was completed 8/13/2025 and the documentation is filed in her chart

moving forward, all PCAs must be med trained. upon completion of the staff orientation, the staff will complete the department approved medication training and the documentation will be filed in the staff's chart. observation training will be 6 months after the initial medication training and every 6 months thereafter. all medication training will be conducted by a department approved personnel; their credentials will also be filed away in the office for review upon request

the administrator is responsible for scheduling all medication trainings with the approved personnel and filing away such completion documents.

(Directed)

- Staff Member D was certified in medication administration on 8/13/25.*
- The administrator will complete an initial audit of all other staff in the home to ensure they have completed the Department approved medication administration course and all required medication observations and MAR reviews are filed in the staff members' records by 9/30/25.*
- Beginning no later than 9/30/25, the administrator will review the staff schedule to ensure a staff member certified in medication administration is scheduled each shift.*
- Documentation if the audit and staff schedules will be kept by the home and available for review by the Department.*

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/28/2025)

16. Requirements

2600.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff member B, the [REDACTED], maintains a list of staff persons that does not include a current list of names and addresses.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

at the time of the inspection, the administrator had three staff members, [REDACTED] [REDACTED]. the administrator had a current list with these staff members information. however, the administrator will ensure that a current list of all staff members' name, phone number and email address are filed in the inspection book for inspectors to review. during the hiring process, after the criminal background check is completed and all orientation hours are completed, the administrator will be sure to add the new hire's information to the current staff list immediately. the administrator is responsible to ensure that a list of staff information is current and accurate. the administrator will complete a list of staff check, monthly, on the last Tuesday of the month effective immediately. further, the administrator will ask staff monthly, on the last Tuesday of each month if any contact information has changed and will revise the list immediately if there has been a change. also, when staff leave from their position, the administrator will, within one business day, delete/erase their information off the list

(Directed)

- The Administrator will create a list of current employees, substitute personnel and volunteers to include the names, addresses, and telephone numbers by 9/30/25.
- Beginning no later than 9/30/25, any newly hired staff member will be added to the list by the administrator upon the staff member's completion of orientation and background check.
- Beginning no later than 9/30/25, the administrator will confirm the staff member's addresses and phone numbers on the last Tuesday of each month and revise the list, as needed.

Directed Completion Date: 09/30/2025

Implemented [REDACTED] - 10/22/2025)

64c - Annual Training

17. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff member B, [REDACTED], did not complete any hours of Department-approved training in the 2024 calendar training year.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

the administrator will complete the required annual trainings as soon as possible. the administrator is responsible to ensure all trainings are complete annually in a timely manner

64c - Annual Training (continued)

(Directed)

- The administrator will develop and implement a 2025 schedule of training specific to the administrator training, which should include a total of 48 hours of training to be completed by 12/31/25 (24 hours for training year 2025 and 24 hours for training year 2024).
- The administrator will have at least 8 hours of Department approved training completed by 9/30/25.
- An annual staff training plan will be developed for the Administrator which will include 24 hours of Department approved training by 9/30/25.
- Beginning no later than 9/30/25, the administrator's training will be monitored through the quality management process to ensure the administrator has 24 hours of Department approved training annually.
- Documentation of completed education and staff training plan for the administration will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [redacted] - 10/22/2025)

65f - Training Topics

20. Requirements

2600.

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff member D, hired in [redacted] 2, did not receive training in any of the training topics as specified in 2600.65(f) during the 2024 calendar training year.

Plan of Correction

Directed [redacted] - 09/17/2025)

staff d will complete all required trainings for the year 2025. the administrator will be responsible for scheduling, tallying training credits and filing proof of completion. effective immediately and continuing ongoing

(Directed)

- Staff member D will receive education in all of the required training topics as identified in 2600.65(f) by 9/30/25.
- The administrator will audit all current staff training records to ensure all staff persons have completed the required training in accordance with regulation 2600.65(f) during the 2024 training year. Any missed training topics will be completed by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete bi-annual audits of all staff training records to ensure staff receive training as identified in 2600.65(f).

65f - Training Topics (continued)

- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/23/2025)

65g - Annual Training Content**21. 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 member D, hired in [REDACTED] 2, did not receive training in any of the training topics as specified in 2600.65(g) during the 2024 calendar training year.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

the administrator will ensure staff D completes the required annual trainings as soon as possible. the administrator is responsible to ensure all trainings are complete annually in a timely manner

(Directed)

- Staff member D will receive education in all of the required training topics as identified in 2600.65(g) by 9/30/25.
- The administrator will audit all current staff training records to ensure all staff persons have completed the required training in accordance with regulation 2600.65(g) during the 2024 training year. Any missed training topics will be completed by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete bi-annual audits of all staff training records to ensure staff receive training as identified in 2600.65(g).
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/23/2025)

81b - Resident Personal Equipment**22. Requirements**

2600.

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

81b - Resident Personal Equipment (continued)

Description of Violation

On 7/16/25, resident #9's roller walker was duct taped on both sides of the bars that connect the front and back wheels.

Plan of Correction

Directed [redacted] - 09/17/2025)

the resident is need of a new roller walker. the administrator will contact the resident's insurance and PCP to request a new walker. once the administrator receives eligibility determination from the PCP or/and insurance, the administrator will have the walker delivered to the home. if the walker cannot be covered through [redacted] insurance, the administrator will contact the resident's family to request purchase of a new walker. the administrator will request the walker be purchased within 30 days. the administrator will remind the resident's family after 15 days of requesting to purchase a new walker effective immediately, the administrator will make monthly checks of all residents' DME. the administrator will create a list of all residents that have DMEs. the administrator will then request for staff to check the resident's equipment during each resident's weekly (thorough) room cleaning. the staff is responsible to document any needed repairs to all DMEs. the staff is responsible for documenting this information in the resident's book stored in the office. once a month, on the last Tuesday of the month, the administrator will thoroughly inspect all residents' (that have) DMEs. the administrator's and staff's inspection will be ongoing and effective immediately. the administrator will also discuss all staff checking and cleaning all DMEs during the weekly room cleaning during the staff meeting on 9/4/2025 as well as during all new hire orientation. the administrator will include this task in the (written) staff duties.

(Directed)

- The administrator will contact the resident's insurance and PCP to request a new walker by 9/30/25. Once the administrator receives eligibility determination from the PCP or/and insurance, the administrator will have the walker delivered to the home.
- If the walker cannot be covered through her insurance, the administrator will contact the resident's family to request purchase of a new walker.
- Until a new walker can be provided to resident #9, the staff will complete safety checks of the resident's walker to ensure it remains appropriate for continued use without risk of injury each shift.
- An audit of all other resident's equipment will be completed by the administrator by 9/30/25-audit will include any concerns with the condition of the equipment and plan to replace or repair. The plan to replace or repair the device(s) will include an interim plan to ensure the resident's safety.
- Beginning 9/30/25, staff will complete weekly checks on all resident equipment.
- Beginning no later than 9/30/25, the administrator will complete monthly checks on all resident equipment.
- All staff will receive education on 2600.81(b) by 9/30/25 by the administration.
- Documentation of completed checks, audits, contact to PCP/Insurance, family, etc. will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented ([redacted] - 10/23/2025)

85a - Sanitary Conditions

23. Requirements

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

85a - Sanitary Conditions (continued)

Description of Violation

On 7/16/25 at 12:25 PM, the chest refrigerator located in the basement had food debris and yellow and brown, unidentified substances covering the bottom.

On 7/15/25 at 9:40 AM, 4 wire mesh containers were sitting on top of the medication cart; each container was labeled with "Am morning", "Lunch", "Dinner", "PM Night". Inside each container were small plastic medication cups, labeled with a resident's name. The cups contained residue from previously administered medications. Staff interviews confirmed the plastic medication cups stored on the medication cart were re-used for each medication administration. Reusing medication cups that previously contained medications creates unsanitary conditions and contamination for medication administration.

Plan of Correction**Directed** [REDACTED] - 09/17/2025)

the refrigerator is clean. the administrator removed all of the food out of the refrigerator, allowed it to cool, then cleaned it out with pine sol and bleach. the administrator returned the food to the refrigerator and threw away any rubbish.

effectively immediately and ongoing the administrator will check each week on Tuesday all freezers and refrigerators for any spills. the administrator will immediately either clean it up or ask staff to clean the spill.

the administrator has developed a new method to administering medication. the administrator has purchased paper disposable medication cups. the administrator has trained all staff on how to properly administer medication using the disposable cups. the administrator purchased new clear plastic cups and labeled each cup with a resident's name. staff are to put all of each resident's medicine in the paper then put it inside the clear plastic cup and then administer the medication giving the resident only the paper cup. staff is to immediately throw away the disposable cup. staff is to return the labeled clear plastic cup to the medication chart. the administrator will demonstrate how to administer the medication using the new disposable cups during the staff meeting on 9/4/2025 as well as during new hire orientation.

(Directed)

- The administrator cleaned the refrigerator by 9/11/25.
- Education will be provided to all staff on keeping the refrigerators and freezers clean by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete weekly audits of all freezers and refrigerators to ensure continued sanitary conditions.
- Beginning no later than 9/30/25, staff will administer resident medications with the use of disposable, paper cups. Staff will place resident medications into the paper, disposable cup only, administer the medications to the resident and immediately dispose of the cup. Paper and/or plastic cups will not be re-used for any step of medication administration to ensure continued sanitary practices.
- Education will be provided to all staff that the re-use of plastic cups or any other reusable item during medication administration, risks contamination and unsanitary conditions during medication administration. Education to be completed by the administration no later than 9/30/25.
- Documentation of education and completed audits will be kept by the home and available for use by the Department.

Directed Completion Date: 09/30/2025

85a - Sanitary Conditions (continued)

Not Implemented [redacted] 10/23/2025)

85d - Trash Receptacles

24. Requirements

2600.

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

Description of Violation

On 7/15/25 at 9:30 AM, there was a 3/4 full, uncovered, unattended trash can in the kitchen.

Plan of Correction

Directed [redacted] - 09/17/2025)

the administrator is unaware of a trash can being uncovered in the kitchen. the administrator always informs all staff of the importance of never to leave the top off the trash can. maybe the uncovered trash can being mentioned in this violation is our recycling can. the administrator was unaware that a recycling can had to be covered the same as a trash can does. the administrator has recently purchased two new cans for the kitchen. the trash can have a top that is attached to the cannister, and the recycling can have a push flip top that clicks shut.

the administrator will mention this violation during the staff meeting on 9/4/2025 and will warn all staff of the consequences of them not being vigilant of the trash cans in all bathrooms

(Directed)

- In addition to the above plan of correction, the administrator will complete audits at least once weekly to ensure trash in kitchens are kept in covered trash receptables; audits to begin no later than 9/30/25.
- Documentation of staff education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [redacted] - 10/23/2025)

85e - Trash Outside Home

25. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 7/17/25, the exterior garbage can was overflowing with trash, preventing the receptacle from being covered.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [redacted] - 09/17/2025)

the administrator will make sure all trash cans are not overflowing by making sure the recycling is ripped into smaller pieces so that more can fit into the receptacles instead of throwing away whole boxes, etc. the administrator will make sure all staff are compliance with this requirement to break down recycling materials at all times by

85e - Trash Outside Home (continued)

discussing this topic during the upcoming staff meeting on 9/8/2025. effective immediately and ongoing, all staff are responsible for breaking down all recycling materials each day.

(Directed)

- In addition to the above plan of correction, the administrator will complete audits at least once weekly, beginning no later than 9/30/25, to ensure trash outside of the home is kept in covered receptacles that prevent the penetration of insects and rodents.
- Documentation of complete education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [REDACTED] - 10/23/2025)

88a - Surfaces**26. 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

On 7/16/25 at 9:55 AM, 3 unpatched holes of drywall measuring at least 3 inches in diameter were located in the ceiling by resident rooms 11,12 and 14; 2 of the holes contained exposed electrical wires.

On 7/16/25 at 10:23 AM, resident #2's bedroom door was missing a door handle. A sharp piece of metal was protruding from the resident's door where the door handle was previously located.

On 7/17/25, the exhaust vent in communal bathroom near resident room 7 was covered in a thick layer of dust with the potential to prevent proper ventilation.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

the administrator will either hire a handy [REDACTED] to patch the holes or request that the electrician that removed the lighting fixtures and left the holes unpatched return to patch the holes in the ceiling by resident rooms 11,12, and 14 within 45 days. the administrator will be sure to conduct a walk through immediately after jobs like this is completed by outside contractors to ensure that [REDACTED] not leave unfinished work. also, the administrator will also only schedule these jobs when the administrator can be present to make sure this is done. the administrator is responsible for this task

on 7/16/205 the administrator purchased a new doorknob and replaced the doorknob on resident's 2's door. the administrator removed the doorknob around 12am on 7/16/2025 to due the resident locking [REDACTED] in the bedroom threatening to harm [REDACTED] because [REDACTED] was upset about something (resident 2 was angry about a lot of things such as the home not having a salad bar, staff not allowing [REDACTED] to talk to them disrespectfully, [REDACTED] not wanting to exit [REDACTED] bedroom so that they can properly clean [REDACTED] room, not being able to store food on [REDACTED] bedroom floor; the list goes on). When the inspector returned on 7/17, the doorknob was replaced, and the requested documented room checks were given to the inspector.

the vent in room 7 was covered with duct tape not the bathroom close to room 7. when the heat is on, the resident's room gets warm, but this resident does not like to be warm at all. [REDACTED] likes for [REDACTED] room to be extremely cold.

88a - Surfaces (continued)

therefore, the administrator upon the resident's request covered one of the two vents located in [redacted] room to avoid [redacted] discomfort. the administrator will remove the duct tape immediately. the only reason duct tape was used because the vent covers purchased at Home Depot continued to fall down and the administrator could not find any closable vent covers locally. the administrator is responsible for ensuring all vents are not covered using duct tape. the administrator will try other hardware store that sells closable vents for size needed to cover the venting hole. the administrator will make sure the holes are patched, and vent cover is replaced within 45 days

(Directed)

- The the holes in the ceiling will be repaired no later than 9/30/25. If the administrator is unable to complete the repair by 9/30/25, the administrator will have documentation of a confirmed, scheduled date of repair from an outside source.
- The administrator will clean the exhaust vent in the communal bathroom near resident room 7 by 9/30/25
- The administrator will complete an an initial walkthrough of the home no later than 9/30/25 to ensure all other floors, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Results will need to be documented with a plan of repair, as needed.
- Education will be provided to all staff on 2600.88(a) by 9/30/25 which will also also include keeping bathroom exhaust vents clean and free of dust to ensure proper ventilation.
- Beginning no later than 9/30/25, the administrator will complete weekly audits of the home to ensure bathroom exhaust fans remain free of dust and floors, walls, ceilings, windows, doors and other surfaces remain clean, in good repair and free of hazards.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [redacted] - 10/23/2025)

91 - Telephone Numbers

27. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 7/15/25, telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline were not posted on or by the telephone near resident bedrooms 11, 12, and 14.

Plan of Correction

Directed [redacted] - 09/17/2025)

the administrator and staff are responsible for ensuring all emergency telephone numbers are displayed by all telephones in the home. The administrator is responsible for posting this list once made aware that the list is missing. staff is responsible for notifying the administrator via communication book. the administrator will read the communication book daily or within one business day and will be sure to post the list. the administrator will discuss this staff responsibility during the next staff meeting on 9/8/2025

91 - Telephone Numbers (continued)

(Directed)

- The administrator will post all required emergency telephone numbers by the telephone located by resident rooms 11, 12, and 14 by 9/30/25.
- Education will be provided to all staff in the home on 2600.91 by 9/30/25.
- The administrator will complete an initial audit of all other telephones with an outside line by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete quarterly audits in the home to ensure emergency telephone numbers are posted on or by each telephone with an outside line.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/23/2025)

95 - Furniture and Equipment

28. Requirements

2600.

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

Description of Violation

On 7/17/25 at approximately 5:00 PM, an electrical duplex outlet located in the staff office was broken with the top plug missing resulting in exposed electrical wires.

On 7/16/25 at 9:55 AM, an air conditioning vent was partially falling out of the ceiling in the back hallway by resident bedrooms 11, 12, and 14.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

the administrator will either hire a [REDACTED] or electrician to fix the electrical wiring in the staff office as well as the vent in the ceiling by resident rooms 11, 12, and 14 within 45 days. the administrator will be sure to fix any issues like there within 30 days with a scheduled repair date. the administrator will only schedule these jobs when the administrator can be present to make sure this is done. the administrator is responsible for this task the vent is not hanging from the ceiling, rather it is uncovered

(Directed)

- The administrator will have all repairs completed by 9/30/25. If the administrator is unable to complete the repairs by 9/30/25, the administrator will have documentation of a confirmed, scheduled date of repair from an outside source.
- Until the electrical outlet can be repaired, the administrator will ensure no items are plugged into the broken outlet and all electrical wires are no longer exposed by 9/30/25.
- Beginning no later than 9/30/25, staff will check the air conditioning vent at least once a shift to ensure it will not fall from the ceiling and injure a resident.
- Education on 2600.95 will be provided to all staff in the home by 9/30/25.
- The administrator will complete an initial audit of all other areas of the home, checking for furniture and equipment to be in good repair, clean and free of hazard by 9/30/25. Audit results will be documented as well as a plan to correct each item.
- Beginning no later than 9/30/25, the administrator will complete monthly audits of the home's furniture

95 - Furniture and Equipment (continued)

and equipment to ensure it is in good repair, clean and free of hazards.

- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/23/2025)

101j6 - Mirror**30. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

6. A mirror.

Description of Violation

There was no mirror in the bedroom of resident #2 on 7/17/25.

Plan of Correction

Directed [REDACTED] - 09/17/2025)

the administrator and staff are responsible for ensuring all bedrooms have a mirror. The administrator is

101j6 - Mirror (continued)

responsible for purchasing all mirrors for residents once notified or observed. staff is responsible for notifying the administrator via communication book. the administrator will read the communication book daily or within one business day and will be sure to purchase and hang the mirror in the resident's room. the administrator will discuss this staff responsibility during the next staff meeting on 9/8/2025

(Directed)

- The administrator will provide a mirror in resident #2's bedroom by 9/30/25.
- The administrator will complete an audit of all other resident rooms by 9/30/25 and provide mirrors as needed.
- Beginning no later than 9/30/25, the administrator will complete quarterly audits in the home to ensure all resident rooms have a mirror.
- Documentation of staff education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [redacted] 10/23/2025)

101r - Bedroom - shades/drapes/window covering

31. Requirements

2600.

101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

The windows in resident bedroom 8 did not have shades, blinds, or shutters.

Plan of Correction

Directed [redacted] - 09/17/2025)

the administrator and staff are responsible for ensuring all bedrooms have curtains, shades, drapes, blinds or shutters on the bedroom window. The administrator is responsible for purchasing all window coverings once notified or observed. staff is responsible for notifying the administrator via communication book. the administrator will read the communication book daily or within one business day and will be sure to purchase and hang the covering in the resident's room. the administrator will discuss this staff responsibility during the next staff meeting on 9/8/2025. if coverings are dirty, it will be the staff's responsibility to clean and rehang immediately

(Directed)

- The administrator will provide shades, blinds or shutters in resident bedroom 8 by 9/30/25.
- The administrator will complete an audit of all other resident rooms by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete quarterly audits of all resident rooms to ensure window coverings are present.
- Documentation of staff education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [redacted] - 10/23/2025)

103e - Left Overs

32. 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

On 7/15/25 at 9:34 AM, the following leftover food in the kitchen refrigerator were not labeled or dated:

- 5 round, Styrofoam containers of baked beans were not labeled with the name of the food or date it was prepared.
- one clear container of pineapple chunks was not labeled with the name of the food or date it was prepared.
- a clear container of hashbrowns was not labeled with the date it was prepared.
- a clear container of fried potatoes was not labeled with the date it was prepared.
- glass mason jar with a creamy white liquid was not labeled with the name of the food or date it was prepared.

Plan of Correction

Directed [redacted] - 09/17/2025)

all food must be labeled and dated effective immediately and ongoing. labels are located in the kitchen drawer and must be used each time any food is not completely served to residents. staff have been trained on this requirement therefore moving forward, there will be immediate consequences to this offense. whichever staff prepares the meal is responsible for labeling and dating the remaining food and storing them in tightly sealed Ziplock bags or plastic see through tubber ware with a top. this topic will be discussed as well as the consequence if violated during the upcoming staff meeting on 9/8/2025

(Directed)

- The administrator will dispose of any leftover food that is not labeled or dated by 9/30/25.
- Education will be provided to all staff on 2600.103(e) by 9/30/25.
- Beginning no later than 9/30/25, daily audits will be completed on the home's refrigerators and freezers to ensure all leftover food is labeled and dated.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [redacted] - 10/23/2025)

103f - Refrigerator/Freezer Temps

33. Requirements

2600.

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

Description of Violation

On 7/15/25 at 9:34 AM, there was no thermometer in kitchen refrigerator/freezer.

Plan of Correction

Directed [redacted] - 09/18/2025)

this is not true information. there is a thermometer in all freezers and refrigerators in the home. the inspector failed to locate it.

(Directed)

103f - Refrigerator/Freezer Temps (continued)

- The administrator will place a thermometer in the refrigerator and freezer by 9/30/25.
- Education will be provided to all staff on 2600.103(f) by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete weekly audits to ensure the refrigerator and freezer have a working thermometer.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [redacted] - 10/23/2025)

107d - Procedure Emergency Management Agency Submission

34. Requirements

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures were not reviewed, updated or submitted to the local emergency management agency in 2024.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [redacted] - 09/18/2025)

the administrator will review, update and submit the home's emergency procedures to the local emergency management within 30 days. proof of submission will be filed in the quality management notebook in the office if the administrator hand delivers the procedures or in a folder in the computer files if submitted via email. this will take place annually and is the responsibility of the administrator.

(Directed)

- The administrator will review the written emergency procedures and make updates as needed by 9/30/25.
- The emergency procedures will be submitted to the local emergency management agency no later than 9/30/25; documentation of the annual review and submission will be filed in the home.
- The administrator will be educated on 2600.107(d) by 9/30/25.
- Beginning no later than 9/30/25, the Administrator will audit the emergency procedures at least once every 6 months to ensure the procedures have been reviewed and submitted annually.
- Documentation of education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [redacted] - 10/23/2025)

109b - Rabies Vaccination

35. Requirements

2600.

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

109b - Rabies Vaccination (continued)

Description of Violation

On 7/15/25, a dog was present in the home. The home did not have a current certificate of rabies vaccination.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

the administrator mistakenly did not add the most recent rabies vaccination. the home's pet does in fact have current rabies vaccination and will be added to the inspection notebook in the pet section within 30 days after the administrator has the clinic email the most current vaccinations.

(Directed)

- The administrator will obtain the vaccination and vaccination records for the dog by 9/30/25 and file the vaccination records in the home.
- Beginning no later than 9/30/25, the administrator will complete quarterly audits to ensure the pet's vaccination remains up to date and proper documentation is filed in the home.
- Documentation of completed audits and pet records will be kept in the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [REDACTED] - 10/23/2025)

121a - Unobstructed Egress

36. 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 7/15/25 at 9:42 AM, a large electrical wire hanging loose on the exterior of the home, prevented the home's rear egress door from opening more than 1-2feet.

On 7/15/25, resident #2's doorknob was removed from the inside of the resident's door. Resident #2 was unable to open the bedroom door and exit when the door was latched shut.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

on 7/16/205 the administrator purchased a new doorknob and replaced the doorknob on resident's 2's door. the administrator removed the doorknob around 12am on 7/16/2025 to due the resident locking [REDACTED] in the bedroom threatening to harm [REDACTED] f because [REDACTED] was upset about something. When the inspector returned on 7/17, the doorknob was replaced, and the requested documented room checks were given to the inspector.

moving forward and effective immediately, the administrator will not remove any doorknobs before a new doorknob is purchased despite of the believed urgency to remove the doorknob to avoid gaining a citation

on 7/15/25 the administrator was informed by staff a that the inspector mentioned wires hanging loose preventing the door opening more than 1-2 feet. this is a little exaggerated because the cable cords could easily be lifted and affixed to the wall as the administrator did upon [REDACTED] return to the home om 7/15. the administrator immediately taped the cable cords to the wall, and the problem was solved. effective within 30 days, once a month, the administrator will conduct exterior checks of the home to ensure all/any outside cords/fixtures are intact. the

121a - Unobstructed Egress (continued)

administrator will conduct these checks as well as other checks on the last tuesday of the month.

(Directed)

- The administrator and all staff will receive education on 2600.121(a) by 9/30/25.
- Resident #2's doorknob was replaced on 7/17/25.
- The cords were affixed to the wall by the administrator on 7/15/25.
- The administrator will complete an initial audit of the home to ensure all stairways, hallways, doorways, passageways and egresses are unlocked and unobstructed by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete weekly audits of the home to ensure ensure all stairways, hallways, doorways, passageways and egresses are unlocked and unobstructed.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented (█) - 10/23/2025)

121b - Locking Device Approval

37. Requirements

2600.

121.b. Doors used for egress routes from rooms and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of residents from the building, unless the home has written approval or a variance from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.

Description of Violation

The door at the kitchen, which is used as an egress route from the front entrance of the home to the back exit of the home was equipped with a locking device that requires a key, preventing immediate egress from the building.

Plan of Correction

Directed (█) - 09/18/2025)

the administrator will be responsible for removing the lock on the kitchen sliding door immediately. the administrator plans to replace the key lock with a "flip lock" which will not require a key within the next 30 days.

(Directed)

- The administrator will remove the lock on the door by 9/30/25.
- The administrator and all staff in the home will receive education on 2600.121(b) by 9/30/25 as well as instructions indicating the door is used as an egress to an exit and will remain unlocked and unblocked at all times.
- Beginning no later than 9/30/25, the administrator will complete an audit of all doors in the home to ensure they are not locked, preventing immediate egress from the building.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

121b - Locking Device Approval *(continued)*

Not Implemented [REDACTED] - 10/23/2025)

123b - Emergency Procedures Posted

38. Requirements

2600.

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

Description of Violation

The home's emergency procedures were not posted in a conspicuous and public place in the home.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

the emergency procedures were stored in the file bins in the office located on top of the staff desk. the administrator will immediately post the procedures in the front hallway which is a conspicuous and public place in the home. the administrator is responsible for ensuring copies of the home's emergency procedures are posted in a conspicuous and public place in the home.

(Directed)

- *The Administrator will post the emergency procedures in the front hallway by 9/30/25.*
- *Education will be provided to all to staff on 2600.123(b) by 9/30/25.*
- *Beginning no later than 9/30/25, the administrator will complete quarterly audits on the posting of the emergency procedures.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: 09/30/2025

Implemented [REDACTED] - 10/23/2025)

127a - Portable Space Heaters

39. Requirements

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

On 7/16/25 at 12:25 PM, a portable space heater was in the home's basement.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

the administrator overlooked a space heater found in the farthest back part of the home. the administrator immediately removed the space heater and placed it in the home's locked shed. the administrator will be responsible for ensuring there are no space heaters in the home. the administrator made a thorough check throughout the house to ensure there were no additional space heaters in any part of the home. staff are also responsible for reporting to the administrator if there are any space heaters in the home. if reported, the administrator will immediately remove it from the home and place it in the home's locked shed

127a - Portable Space Heaters (continued)

(Directed)

- The Administrator will remove the space heater from the the property, including the locked shed, by 9/30/25.
- An audit of the entire property will be completed by the administrator by 9/30/25 to ensure no additional space heaters are present.
- Education will be provided to all staff by 9/30/25 on 2600.172(a) by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete monthly audits in the home to ensure space heaters are not present.
- Documentation of completed education and audits will be kept by the home and available for review by the Department,

Directed Completion Date: 09/30/2025

Not Implemented [redacted] - 10/23/2025)

132b - Safety Inspection/Fire Drill

40. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and drill observed by a fire safety expert was conducted on 5/11/23.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [redacted] - 09/18/2025)

it has been extremely difficult to have a fire expert conduct the annual fire drill. the administrator has contacted BFPE, new freedom fire department, and Shrewsbury fire department. the administrator has also contacted another fire expert company but has not had any luck scheduling a fire drill with these fire experts. the administrator will continue to conduct monthly fire drills with evacuation times under 2 minutes and 30 seconds until a fire expert can complete the annual fire drill with the home. the administrator is responsible for locating a fire expert within the next 60 days

(Directed)

- An annual fire safety inspection and drill observed by a fire safety expert will need to be completed by 9/30/25. If an expert is not available to complete this requirement by 9/30/25, written confirmation of the scheduled inspection and observation will be obtained by the administrator from the fire safety expert.
- The administrator will receive education on 2600.132(d) by 9/30/25.
- Beginning 9/30/25, the administrator will review the fire safety inspection and fire drill observation once every 6 months to ensure continued compliance with 2600.132(b).
- Documentation of education, fire safety inspection and observed fire drills completed by a fire safety expert will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [redacted] - 10/23/2025)

132h - Designated Meeting Place

42. 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

Multiple resident interviews indicated that residents do not evacuate to a designated meeting place away from the building or within the fire-safe area during monthly fire drills.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [redacted] - 09/18/2025)

this is not true information

all residents walk to the mailbox when we use the side door as an exit; and to the middle of the street when we use the front door. all residents agree to fully participate in fire drills. I do not have problems with residents participating, they all know where to go when we have a fire drill.

(Directed)

- The administrator will educate all staff and residents on the requirement for residents to participate during fire drill evacuations by 9/30/25.*
- Beginning no later than 9/30/25, the administrator will observe each monthly fire drill to ensure all residents in the home are evacuating to a designated meeting place away from the building or within the fire-safe area during each drill. The administrator will include her initials on the fire drill record to indicate the drill was observed and all residents participated.*
- Documentation of resident and staff education as well as fire drill observations will be kept by the home and available for review by the Department.*

Directed Completion Date: 09/30/2025

Implemented [redacted] - 10/23/2025)

132i - Testing Fire Alarm

43. Requirements

2600.

132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

Multiple resident interviews indicated that a fire alarm or smoke detector is not set off during each fire drill.

Plan of Correction

Directed [redacted] - 09/18/2025)

this information is not true

the fire alarm or smoke detectors are always set off during each fire drill

(Directed)

- The administrator will educate all staff on 2600.132(i) by 9/30/25.*
- Beginning no later than 9/30/25, the administrator will observe each monthly fire drill to ensure a fire alarm or smoke detector is set off during each fire drill. The administrator will document [redacted] initials on the fire drill record to indicate the fire alarm or smoke detector was set off during each drill.*
- Documentation of staff education as well as fire drill observations will be kept by the home and available for review by the Department.*

132i - Testing Fire Alarm (continued)

Directed Completion Date: 09/30/2025

Implemented [redacted] - 10/23/2025)

133.2 - Exit Signs Direction

44. Requirements

2600.

133.2. Exit Signs - The following requirements apply for a home serving nine or more residents: If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

Description of Violation

The residents in bedrooms 6, 7, and 8, did not have a direct visual line to the nearest exit. On 7/15/25, the home served 12 residents.

Plan of Correction

Directed [redacted] - 09/18/2025)

the administrator will purchase a red reflective exit sign in the hallway near bedrooms 6, 7 and 8, effective immediately. the administrator as well as all staff are responsible for ensuring all hallways are marked with readily visible signs indicating the direction to exit. if staff are to find that an exit sign is missing or damaged, that staff is responsible for documenting this information in the staff communication book immediately. the administrator will be responsible for purchasing a new sign as well as hanging the sign in the appropriate location within one business day of reading the communication book. the administrator is also responsible for reading the communication book daily or within one business day. the administrator will include this staff duty requirement in the upcoming staff meeting on 9/8/25

(Directed)

- The administrator will purchase a red reflective exit sign and install the sign in the hallway near bedrooms 6, 7 and 8 by 9/30/25.
- The administrator will receive education on 2600.133(a)(2) by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete monthly audits of the home to ensure the exit or way to reach the exit is visible or that there are signs indicating the direction to travel.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [redacted] - 10/23/2025)

141a - Medical Evaluation

45. 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 #4, date of admission [redacted]/25, did not have a medical evaluation completed within 60 days prior to admission or within 30 days after admission; the resident's medical evaluation was completed on [redacted]/24.

141a - Medical Evaluation (continued)

Resident #8, date of admission [REDACTED]/25, did not have a medical evaluation completed within 60 days prior to admission or within 30 days after admission of the resident; the resident's medical evaluation was completed on [REDACTED]/24.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

the administrator will ensure all DME are completed in a timely manner or/and prior to admission effective immediately and continuing ongoing

(Directed)

- The administrator will complete an audit of all current resident medical evaluations and dates of completion by 9/30/25.
- The administrator will receive education on 2600.141(a) by 9/30/25.
- Beginning no later than 9/30/25, the administrator will audit a resident's medical evaluation within 15 days of admission to ensure a medical evaluation has been completed or scheduled to be completed within 60 days prior to the admission or within 30 days after admission.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/23/2025)

141a 1-10 Medical Evaluation Information

46. Requirements

2600.

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

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

Description of Violation

Resident #1's medical evaluation, dated [REDACTED]/25, did not include body positioning and movement, immunization history, medical information pertinent to diagnosis and treatment in case of an emergency, special health or dietary needs of the resident.

Resident #8's medical evaluation, dated [REDACTED]/24, did not include a current list of medications.

141a 1-10 Medical Evaluation Information (continued)

Plan of Correction**Directed** [REDACTED] - 09/18/2025)

the administrator will ensure all forms are completed in its entirety prior to admission effective immediately and ongoing

(Directed)

- *Resident #1 and #8's medical evaluations will be sent back to the physician for completion or the home will have a new medical evaluation completed for the residents by 9/30/25.*
- *The administrator will review all current medical evaluations to ensure completion. Incomplete medical evaluations will be returned to the physician for completion or new medical evaluations will be scheduled by 9/30/25.*
- *Beginning no later than 9/30/25, the administrator will review all newly completed medical evaluations for accuracy and completion within 2 days of the residents' completed medical evaluation.*
- *Documentation of audits will be kept by the home and available for review by the Department.*

Directed Completion Date: 09/30/2025**Implemented** [REDACTED] - 10/24/2025)

161d - Dietary Needs

47. Requirements

2600.

161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

Resident #4 was prescribed a pureed diet on [REDACTED] 1/24 due to Esophageal Dysphagia. However, the resident received a turkey salad sandwich with shredded turkey meat and cheese puffs for lunch on 7/17/25. According to the National Dysphasia Diet (NDD), pureed food should be "pudding-like" with no coarse textures. Breads should be avoided unless commercially or facility-prepared pureed bread mixes or pre-gelled slurried breads that are gelled through the entire thickness of the product. Whole or ground meats should be avoided.

Plan of Correction**Directed** [REDACTED] - 09/18/2025)

the resident's DME will be updated to reflect the correct diet for resident 4. the administrator will ensure all diets are accurately documented prior to admission effective immediately moving forward and ongoing

(Directed)

- *Beginning immediately, resident #4 will receive the resident's currently prescribed diet.*
- *If the home feels the prescribed diet is inaccurate, the prescribed diet will be served until the home contacts the physician and receives an order for a dietary change.*
- *An audit on all resident dietary orders will need to be completed by 9/30/25.*
- *The administrator will interview all residents and observe a meal by 9/30/25 to determine if resident's dietary needs have changed by 9/30/25. If a resident is observed to have or expresses difficulty safely consuming*

161d - Dietary Needs (continued)

the meal served, the administrator will consult with the resident's physician by 9/30/25.

- Education will be provided to all staff in the home on resident #4's current dietary order and any other resident's dietary needs by 9/30/25.
- Beginning no later than 9/30/25, the administrator will observe resident meals at least three times per week to ensure dietary orders are being followed.
- Documentation of staff education, audits, observations and resident interviews will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [redacted] - 10/24/2025)

171b2 - Staff Age

48. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

2. The driver of a vehicle shall be 18 years of age or older and possess a valid driver's license.

Description of Violation

On [redacted]/25 at approximately 9:15 AM, a 14-year-old drove a vehicle with resident #8 present approximately 15-25 feet up the street.

Plan of Correction

Directed [redacted] - 09/18/2025)

I instructed my [redacted] to sit in the car with resident 8 while I had to get something from the home. I was taking resident 8 to the senior center and [redacted] was accompanying me. while I was in the home getting something I needed, the rabbit transit bus came to pick up my other residents to take them to the senior center. I parked my car directly in front of the home blocking the walk path and [redacted], without my permission, moved the car literally 10 feet so that the rabbit transit could park in front of the walkway so that my other residents could get on the bus. I did not instruct [redacted] to move my vehicle especially with resident in the car. I have spoken with my [redacted] r and [redacted], [redacted] just wanted to do a good deed and move the vehicle out the way so that rabbit transit could pick up my other residents. this will never happen again.

(Directed)

- The administrator will provide education to all staff, residents and family members in the home on 2600.171(b)(2).
- Beginning no later than 9/30/25, resident's will not be left unattended in a vehicle without a driver of a vehicle present who is 18 years of age or older and possess a valid driver's license.
- Documentation of education will be kept by the the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [redacted] - 10/24/2025)

171b5 - First Aid Kit

49. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the Toyota Prius hatchback, used to transport resident #8 on [redacted]/25, did not include nonporous disposable gloves, antiseptic, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Plan of Correction

Directed [redacted] - 09/18/2025)

the administrator will purchase a fully equipped first aid kit for my vehicle effective immediately. the first aid kit that my car has, does not include all of the required items. the administrator will ensure that all first aid kits are fully equipped with all required items by comparing the contents of the first aid kit to the list of required items specified in 2600.96 prior to purchase. the administrator will check the contents quarterly as well as after each use. the administrator is responsible for checking every first aid kit in the home as well as my vehicle. this will be completed within 30 days

(Directed)

- The administrator will purchase a first aid kit and place it in the vehicle by 9/30/25.
- Education will be provided to all staff, including the Administrator, on 2600.171(b)(5) by 9/30/25.
- Beginning no later than 9/30/25, the administrator will audit the vehicle's first aid kit quarterly
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [redacted]/24/2025)

50. Prescription Medication

WITHDRAWN

CR 11/24/25

51. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

Description of Violation

On 7/5/25 at 7:00 AM, staff member B, an unlicensed staff member, administered Cyanocobalamin 1000mcg/ml, inject 1 ml intramuscularly to Resident #1.

Plan of Correction

Directed (CR - 09/18/2025)

this is not true. the resident was prescribed a pill form of this medication. due to the home not permitted to inject medication. the medication was stored in the med cart because the hospital prescribed it upon discharge, but the administrator requested a pill form

(Directed)

- Correction: the violation description is for resident #5's medication.
- The administrator will contact the physician to receive an order for an alternative route of administration for

183a - Original Containers and Injections

52. Requirements

2600.

183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On 7/15/25, the following medications were located in the home's medication cart stored in Ziplock bags:

- resident #2's "Losartan 50mg" -2, whole tablets and 5, half tablets.
- resident #2's "Carvedilol 3.125mg"-2 round, white pills.
- resident #10's "Sertraline 25mg" -10 pills that had been cut in half.
- resident #11's "Amlopine 5mg" -3 round, white pills.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

medication shall not be stored in Ziplock bags. the administrator is responsible for ensuring all medication remain in the original package with the appropriate label.

(Directed)

- The administrator will have the identified medication destroyed by 9/30/25.
- The administrator will receive education on 2600.183(a)(1) and provide education to all other staff by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete at least one medication administration observation per week to ensure medications are not removed more than 2 hours in advance of the scheduled administration.
- Documentation of completed education and observations will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [REDACTED] - 10/24/2025)

183b - Meds and Syringes Locked

53. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 7/15/25, the following medications were unlocked, unattended and accessible in the home:

- At 10:22 AM, 22 Benadryl tablets located in the staff office.
- At 9:52 AM, two bottles of Tylenol 500mg located in resident #5's bedroom; resident #5 is not assessed to self-administer medications.
- At 12:32 PM, Albuterol HFA inhaler was being carried around the home by resident #1; resident #1 is not assessed to self-administer medications.
- At 9:40 AM and again at 10:30 AM, weekly roll of medications prescribed for resident #12 located on the cabinet above the medication cart.

Plan of Correction

Directed [redacted] - 09/18/2025)

the administrator has removed the medication from resident 5's bedroom

the administrator removed [redacted] box of Benadryl

the administrator has informed all staff not to allow resident 1 to keep [redacted] rescue inhaler on [redacted] person.

the administrator has removed all medications belonging to discharged residents

(Directed)

- The administrator will complete an audit of the home by 9/30/25 to ensure all other medications are kept in an area or container that is locked. The audit will include the results and the plan of action to correct the initial findings.
- The administrator will provide education to all staff and residents on 2600.183(b) by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete weekly audits in the home to ensure medications remain kept in an area or container that is locked.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [redacted] - 10/24/2025)

183d - Prescription Current

54. 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

On 7/15/25, the following medications prescribed for resident #12 were in the home; however, the resident was discharged from the home on 7/13/25: Citalopram 20mg, Metformin 500mg, Risperidone 0.5mg, Rosuvastatin 10mg, Montelukast 10mg, Nebivolol 5mg.

On 7/15/25, ammonium lactate lotion prescribed for resident #13 was in the home; however, resident #13 was discharged from the home in November [redacted].

183d - Prescription Current (continued)

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

the administrator will discard all old medication from discharged or deceased residents on the day of discharge or the day after death of a resident. the administrator will be responsible for discarding all medication or assigning staff to dispose medication at the Springfield police station

(Directed)

- The medications identified for residents #12 and #13 will be discarded or destroyed by the administrator by 9/30/25.
- The administrator will educate all staff on 2600.183(d) by 9/30/25.
- The administrator will complete an initial audit of all medications in the home by 9/30/25 to ensure only current prescription, OTC, sample and CAM for individuals residing in the home are kept in the home.
- Beginning no later than 9/30/25, the administrator will complete an audit of all medications within 1 day of a resident being discharged to ensure only medications for current residents are kept in the home.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/28/2025)

183e - Storing Medications

55. 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

On 7/15/25 at 12:32 PM, an orange, round pill was loose in the home's medication cart.

On 7/15/25 at 12:30 PM, a used Lantus Solostar insulin pen belonging to resident #3 was in the medication cart and not labeled with the date it was opened.

On 7/16/25, at approximately 3:00 PM, resident #3's blister pack containing Warfarin 2mg tablets had a piece of tape over the foil backing to secure a pill.

On 7/15/25 at 12:30 PM, resident #7's Breo Ellipta inhaler was open, in use, and not labeled with the date opened.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

the administrator has trained staff on labeling opened medications. all staff are responsible for labeling

183e - Storing Medications (continued)

medications as they are opened. no staff is to repackage medications, instead they are to properly dispose them. staff are to be vigilante on loose pills that may have fallen out of the original package after each medication administration. staff are to dispose all medications that have been dropped out of the package. the administrator will complete weekly checks as well to make sure there are n pills dropped in the medication cart. the administrator will create a medication cart cleaning reminder sheet that will remain on top of the medication cart to serve as a reminder for all staff to check for loose pills effective immediately and continuous for 30 days

(Directed)

- The above training will be completed with all staff by 9/30/25.
- The administrator's weekly checks will begin no later than 9/30/25 and will ensure medications are dated when opened, no medications are loose in the medication cart and medications are properly stored in the packaging.
- The administrator will discard and order new insulin pens for residents #3 and #7 by 9/30/25.
- The loose pill found in the medication cart will be destroyed by the administrator by 9/30/25.
- The pill found taped into the foil Warfarin blister packet will be destroyed by the administrator by 9/30/25.
- The administrator will create a medication cart cleaning reminder sheet that will remain on top of the medication cart to serve as a reminder for all staff to check for loose pills effective no later than 9/30/25 and continuous for 30 days.

Directed Completion Date: 09/30/2025

Not Implemented (█ - 10/24/2025)

184a - Resident's Meds Labeled**56. 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.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #3's Ketoconazole cream 2%, did not have a pharmacy label to include: the resident's name, the name of the medication, the the prescribed dosage and instructions for administration, and the name and title of the prescriber.

On 7/15/25 at 12:25 PM resident #3's Lantus Solostar insulin pen was not labeled with the resident's name or the staff's initials that opened the insulin pen.

Resident #3 was prescribed Lantus insulin, inject 32 units under the skin twice daily; however, the pharmacy label provided directions to inject 30 units under skin at bedtime.

Plan of Correction

Directed (█ - 09/18/2025)

the administrator will make sure all medications have pharmacy labels upon receipt, moving forward and ongoing

184a - Resident's Meds Labeled (continued)

effective immediately

(Directed)

- The administrator will receive updated pharmacy labels or new medications with proper labeling for resident #3 by 9/30/25.
- The administrator will complete an audit on all resident medications and physician's orders to ensure the pharmacy label includes all items required in 2600.184(a) as well as ensuring insulin pens are labeled with the staff member's initials upon opening the pens.
- The administrator will provide education to all staff in the home on comparing pharmacy labels to current orders to ensure proper medication administration is occurring as well as 2600.184(a) by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete monthly audits of resident medication pharmacy labels compared to physician's orders.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented (█) - 10/24/2025)

184b - Labeling OTC/CAM**57. Requirements**

2600.

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

Description of Violation

On 7/15/25, two bottles of Acetaminophen 500mg tablets were stored in the top drawer of the daily medication cart and were not labeled with the resident's name.

On 7/17/25, the following over-the-counter medications were in the home's as needed medication cart, and were not labeled with the resident's name:

- Equate Gentle Lax
- Equate Gas Relief
- AREDS 2
- Antacid Tab

Repeated Violation - 11/21/24, 7/9/24, et al.

Plan of Correction

Directed (█) - 09/18/2025)

these medications were used for a current resident's pre op medications. the administrator has been informed to dispose all of these medications; therefore, the administrator has properly disposed them

(Directed)

- The administrator will provide education to all staff on 2600.184(b) by 9/30/25.
- An initial audit of all medications will be completed by the administrator by 9/30/25 to ensure OTC medications are identified with the resident's name.
- Beginning no later than 9/30/25, the administrator will complete monthly audits of the home's medication

184b - Labeling OTC/CAM (continued)

cart to ensure OTC medications are identified with the resident's name.

- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/24/2025)

185a - Implement Storage Procedures**58. 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

On 7/16/25, the following medications prescribed for Resident #7 were not available in the home:

- Cetirizine 10mg, as needed for Allergies
- Loperamide 2mg, as needed for Diarrhea
- Loratadine 10mg, as needed for Allergies
- Ondansetron 4mg, as needed for nausea or vomiting
- Acetaminophen 500mg, as needed for moderate pain, headache, or fever > 101
- Albuterol Sul HFA inhaler, as needed for wheezing or shortness of breath

Resident #3 receives weekly blood sugar checks with a glucometer. The following blood glucose levels were stored in the resident's glucometer and were not documented in the resident's record:

- 6/30/25-224
- 6/16/25-208
- 6/9/25-234
- 6/2/25-199
- 5/19/25-162
- 5/5/25-209

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

all PRN meds have been ordered, moving forward and continuing ongoing, the administrator will refill all medications prior to expiration and in a timely manner moving forward.

resident's #3 blood glucose is recorded but not in the resident's individual chart. the administrator keeps a record of all resident's vitals. the administrator will record the information and file them in each resident's individual's chart. this task will take time so that the administrator can separate all of the vitals and file them in each resident's chart therefore, this task will be completed within 45 days

185a - Implement Storage Procedures (continued)

(Directed)

- Resident #7's medications will be made available in the home by 9/30/25.
- An initial audit of all other resident medications will be completed to ensure medications are available in the home for administration by 9/30/25.
- Beginning no later than 9/30/25, all residents who receive blood sugar checks will have their blood glucose levels documented in their records.
- The administrator will complete an investigation into resident #2's missing Trazadone medication by 9/30/25.
- The administrator will provide education to all staff on ordering medications to ensure medications are always available in the home and documenting resident blood sugars in the resident's record by 9/30/25.
- Beginning no later than 9/30/25, the administrator will complete monthly audits to ensure resident medications are available as ordered and resident blood glucose levels are documented in the resident records.
- The administrator will review the home's current policy and procedures to investigate and account for missing medications and medication errors. Updates to the policy will be made as necessary and staff will receive education on the policy by 9/30/25.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/28/2025)

186b - Medication Used by Resident

59. Requirements

2600.

186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On 7/15/25, staff member A reported resident #1 was administered Ammonium Lactate lotion prescribed for and belonging to resident #13.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

staff member A reported that [REDACTED] used lotion located in the cabinet but not ammonium lactate lotion. staff A was referring to the bottle of Aquaphor lotion that was located in the same cabinet as the other lotion. since the inspection, the ammonium lactate lotion has been thrown away

(Directed)

- The administrator will provide education to all staff on 2600.186(b) by 9/30/25.
- Beginning no later than 9/30/25, the administrator will observe medication administration for each staff member per month to ensure the medications prescribed to the resident are being administered to the resident.
- Documentation of education and observations will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

186b - Medication Used by Resident (*continued*)

Implemented [REDACTED] - 10/24/2025)

187a - Medication Record

60. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #5 is prescribed Ultra Lubricating Eye Drops, every 4 hours as needed;, however, this medication is not included on the resident's July 2025 Medication Administration Record (MAR).

Resident #3 is prescribed Lantus insulin, inject 32 units twice daily; however, the resident's July 2025 MAR included instructions to inject 32 units under skin at bedtime.

Resident #7 is prescribed Methimazole 5mg; however, the resident's July 2025 MAR did not indicate the diagnosis or purpose for the medication.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

the administrator contacted resident #3 PCP as well as the pharmacy to inform the inspector the information typed on the MAR was incorrect due to pharmacy error. moving forward and ongoing the administrator will check MARs for accuracy and will request a corrected form be immediately sent to the home instead of waiting for the next month it be corrected by the pharmacy

Resident #5 bought those drops from home and was not permitted to have them. the administrator has strongly informed family not to bring any medication to the residents, instead give all medication to staff and the administrator will verify if medication is currently prescribed. the administrator has also instructed all staff to look in each resident's room at least weekly to ensure no medication is in rooms unless [REDACTED] can self-medicate, effective immediately.

the administrator will make sure all MARs include the diagnosis and/or purpose for all medications. the administrator will audit all MARs effective immediately and ongoing

(Directed)

187a - Medication Record (continued)

- The administrator will update resident #3 and resident #7's Medication Administration Records (MARs) by 9/30/25.
- The administrator and all staff will receive education on 2600.187(a) by 9/30/25.
- The administrator will complete an initial audit on all resident MAR's by 9/30/25 to ensure initial compliance with 2600.187(a).
- Beginning no later than 9/30/25, the administrator will audit at least 3 resident MAR's per month.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/27/2025)

187b - Date/Time of Medication Admin.**61. 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 #5 was administered Clotrimazole Cr 1% on 7/8/25. However, the resident's July 2025 Medication Administration Record (MAR) does not include staff member B's initials, who administered the medication.

Resident #5 was administered [REDACTED] daily, prescribed medications from 7/8/25 through 7/15/25; however, the names and initials of the staff person administering the medications was not recorded until 7/16/25.

On 7/15/25, at approximately 12:20 PM, staff member A administered Tylenol and Levetiracetam to resident #14. However, the name and initials of staff member A was not recorded until after 4:00 PM.

Plan of Correction

Directed [REDACTED] - 09/18/2025)

all staff are to properly record medication administration in a timely manner. the administrator will review the MAR at least every other day to ensure records are accurate. staff is responsible for documenting properly daily. consequences such as retraining, suspension, or termination will result in medication administration errors effective immediately and continuing ongoing

(Directed)

- The administrator will provide education to all staff on 2600.187(b) by 9/30/25.
- Beginning no later than 9/30/25, the administrator will review resident MAR's at least once weekly to ensure the name and initials of the staff person administering the medication is recorded at the time the medication is administered.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/27/2025)

187c - Refusal of Medication

62. Requirements

2600.

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

Description of Violation

On 6/9/25, resident #2 refused the following prescribed medications which were not reported to the prescriber:

- 7:00 AM-Amiodarone 20mg, take 1 tablet by mouth daily for Arrhythmia
- 7:00 AM-Aspirin 81mg, take 1 tablet by mouth daily for Prophylaxis
- 7:00 AM-Atorvastatin 40mg, take 1 tablet by mouth daily for High Cholesterol
- 7:00 AM and 7:00 PM-Carvedilol 3.125mg-take 1 tablet by mouth twice daily for HTN
- 7:00 AM-Ezetimibe 10mg, take 1 tablet by mouth daily for High Cholesterol
- 7:00 AM-Folic Acid 0.4mg, take 2 tablets by mouth daily for Supplement
- 7:00 AM, 12:00 PM, 5:00 PM, and 7:00 PM-Iprat-Albut 0.5-3mg, inhale 1 vial via nebs four times a day for COPD
- 7:00 AM and 7:00 PM-Levetiracetam 1000mg, take 1 tablet by mouth twice a day for Seizures
- 7:00 AM-Losartan 25mg, take 1 tablet by mouth daily for HTN
- 5:00 PM-Metformin ER 500mg, take 1 tablet by mouth every evening for Diabetes
- 7:00 AM-Pantoprazole DR 40mg, take 1 tablet by mouth daily for GERD
- 7:00 AM-Zinc Gluconate 50mg, take 1 tablet by mouth daily for Supplement

Plan of Correction

Directed [REDACTED] - 09/18/2025)

the administrator will report all refusals within 24 hours to the resident's PCP to ensure compliance with state regulations. the administrator will record the personnel that the refusals are reported to and keep track of all refusal communication in the resident's chart effective immediately and continuing ongoing. the administrator will create a refusal communication sheet. all staff are to report to the administrator all refusals and it will be the responsibility of the administrator to contact and document all communication with the resident's medical team about the refusal. staff are to attempt to administer the medication prior to the medication administration "window"

(Directed)

- The administrator will report the refusals as identified in the violation to the prescriber by 9/30/25.
- The administrator will provide education to all staff on 2600.187(c) by 9/30/25.
- The administrator will create a refusal communication sheet by 9/30/25 on which staff are to report to the administrator all resident medication refusals. The administrator will review the communication sheet daily and report the refusals to the prescriber.
- Documentation of completed education and communication with the prescriber will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/27/2025)

190b - Insulin Injections

63. Requirements

2600.

190b - Insulin Injections *(continued)*

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff member B, who has not successfully completed a Department-approved diabetes patient education program with in the last 12 months, completes weekly blood glucose testing for residents #2 and #3.

Plan of Correction

Directed (█ - 09/18/2025)

the administrator paused all glucose testing until all staff, at that time, completed the (scheduled) department approved glucose training through well span on 7/28/25. the administrator will ensure all staff are trained annually without any gaps in training moving forward and ongoing.

(Directed)

- *The administrator will audit all current staff records by 9/30/25 to ensure staff member's assisting residents with blood glucose testing and insulin administration have successfully completed the Department-approved diabetes education program within the past 12 months.*
- *The home will continue to provide diabetic services by contracting with an agency to monitor blood glucose levels and/or administer insulin to all residents, as needed, until staff members have received required training.*
- *Beginning no later than 9/30/25, the administrator will audit all staff diabetic education records quarterly to ensure they remain current.*
- *Documentation of completed audits and education will be kept by the home and available for review by the Department.*

Directed Completion Date: 09/30/2025

Implemented (█ - 10/27/2025)

224a - Preadmission Screen Form

64. 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 #5 was admitted to the home on █/25 and resident #4 was admitted to the home on █/25; however, the residents' preadmission screening forms do not include the date of completion as this section was blank.

Repeated Violation - 7/9/24., et al.

Plan of Correction

Directed (█ - 09/18/2025)

effective immediately, the administrator will be sure to double check to ensure the completion date is included on the prescreening form. this is the responsibility of the administrator to ensure accurate and complete information is included on all forms. the administrator will be sure to specifically look at the date section to make sure it is filled in. the administrator will make that the first section to complete when visiting a potential resident moving forward and ongoing

224a - Preadmission Screen Form (continued)

(Directed)

- *The administrator will complete an initial audit of all other residents in the home to ensure the preadmission screening forms are completed thoroughly and properly and have been completed per regulatory time requirements by 9/30/25. Audits will include areas of compliance or non-compliance found.*
- *Beginning no later than 9/30/25, the administrator will audit resident records within 1 day of admission to ensure the Department's preadmission screening form is completed properly and thoroughly.*
- *Documentation of completed audits will be kept in the home and available for review by the Department.*

Directed Completion Date: 09/30/2025**Implemented** [REDACTED] - 10/28/2025)

225a - Assessment 15 Days

65. 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 #1's assessment, dated [REDACTED]/25, includes the following diagnoses: high cholesterol, high blood pressure, chronic pain, chronic asthma, cognitive issues. However, resident #1 is prescribed medications for hyperlipidemia, wheezing, constipation, and also has the following diagnoses: sepsis, influenza, CAP, altered mental status, atrial fibrillation with RVR, cardiomyopathy, elevated troponin, severe aortic stenosis, chronic anemia, aortic aneurysm of abdomen, and ongoing pressure injury stage I and II. These diagnoses and conditions are not indicated on the resident's assessment.

Resident #1's assessment, dated [REDACTED]/25, indicated the resident does not walk, staff must transfer resident to their wheelchair and the resident must be in their wheelchair at all times. However, resident #2 is able to self-propel [REDACTED] manual wheelchair which is not indicated on the resident's assessment.

An assessment was not completed for resident #2, who was admitted to the home on [REDACTED]/25.

An assessment was not completed for resident #8, who was admitted to the home on [REDACTED]/25.

Resident #3's assessment, dated [REDACTED] 24, indicated the resident's "left leg from the knee down is amputated"; however, resident #3's left leg is not amputated; the resident's right leg is amputated above the knee.

Resident #4's assessment, dated [REDACTED]/25, indicated the resident requires total physical assistance to obtain clean clothing and that the resident needs assistance with obtaining seasonal clothing. Resident #4 wore the same articles of clothing on 7/15/25, 7/16/25 and 7/17/25. The description of service need did not identify the resident's area of need to obtain clean clothing each day.

Repeated Violation - 12/17/24, 7/9/24, et al.

225a - Assessment 15 Days (continued)

Plan of Correction

Directed [redacted] - 09/18/2025)

effective immediately, the administrator will be sure to verify all information prior to completing the RASP.

Resident #4 still has a right to decide what clothes [redacted] would like to wear and if you know resident #4 [redacted] only like to wear certain clothing and therefore staff respects [redacted] right to make that decision, however, [redacted] clothes are cleaned and was cleaned but was returned to [redacted] so [redacted] can have dignity in [redacted] decision to wear the clothes [redacted] wishes to wear

this duty is the responsibility of the administrator and will begin immediately for any and all new admissions

(Directed)

- The administrator will receive education on 2600.225(a) by 9/30/25.
- The administrator will update assessments for residents residents #1, #3 and #4 by 9/30/25.
- The administrator will complete assessments for residents #2 and #8 by 9/30/25.
- The administrator will complete an initial audit of all other resident assessments by 9/30/25 to ensure they properly assess and reflect all of the residents' needs and have been completed within the regulatory timelines.
- Beginning no later than 9/30/25, the administrator will audit all new resident assessments within 10 days of admission to ensure they are completed timely and properly reflect residents needs.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [redacted] - 10/27/2025)

227a - Support Plan 30 Days

66. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #2 was admitted on [redacted]/25; however, the resident's initial support plan was not completed.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [redacted] - 09/18/2025)

the administrator has completed a RASP on the resident but since the inspection, the resident has been discharged the administrator will be responsible for ensuring all RASP are developed in a timely manner effective immediately. the administrator will write on a desk calendar the day of admission and count 25 days after and at that time have a staff meeting to gather all pertinent information about the resident and on the 29th day, develop, discuss, sign, date and file the RASP. this is effective immediately and continuing on going. this will begin for the next admission; all admissions are n pause until at least 10/01/25

(Directed)

227a - Support Plan 30 Days (continued)

- In addition to the above plan of correction, the administrator will audit all other resident support plans by 9/30/25 to ensure they were completed timely. Documentation of the completed audit will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] - 10/27/2025)

227d - Support Plan Medical/Dental

67. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #1 has bilateral half-rails on [REDACTED] bed. The resident's support plan, dated [REDACTED]/25, does not include any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Resident #4's support plan, dated [REDACTED]/25, indicated resident #4 needs [REDACTED] meats blended and all other food soft. Staff will blend all of the resident's meats before serving and will not serve any hard food such as salads, fried foods etc. Staff will ensure none of the resident's food is hard or crunchy. However, the resident's medical evaluation, dated [REDACTED]/24, indicated a special diet of pureed foods.

Plan of Correction

Directed [REDACTED] - 09/19/2025)

Resident #1 feels secure in a hospital bed with half rails. the revised RASP will support this need as well as an order from [REDACTED] PCP. The administrator is responsible for obtaining this document from [REDACTED] PCP as well as indicating the need in [REDACTED] RASP. The administrator has requested the order and will include it in resident's #1 chart upon receipt.

Resident's outdated DME suggested pureed diet, however when attending [REDACTED] most current PCP appointment with [REDACTED] new PCP, this dietary need is no longer necessary, only a chopped diet. The administrator will request a new DME is completed by resident's #4 new PCP that shall reflect this information. The administrator is responsible for obtaining this information, including it in [REDACTED] revised DME and making sure this is implemented during each meal. The administrator will include the topic of proper meal preparation for each resident in the upcoming staff meeting; consequences will follow for any and all incompliances.

Effective immediately, the administrator will review all RASP to ensure that all residents are receiving the appropriate care and has updated information in the DME and RASP. This review will take place within 45 days, and the administrator will verify all information in each RASP and DME aligns to ensure we serve optimum care. prior to admission, the administrator will ensure to speak to the potential resident's medical team to make sure all information received is accurate and up to date, the administrator will record the name of the person spoken to effective immediately for all upcoming admissions.

(Directed)

- The administrator will remove resident #1's bedrails by 9/30/25. If the resident needs assistance with

227d - Support Plan Medical/Dental (continued)

turning and positioning in bed, the administrator will provide assistance to assess the resident for use of an alternative bed mobility device. Resident #1's support plan will be updated by 9/30/25.

- Until a new order is received for resident #4's dietary needs, the resident's support plan will be updated by 9/30/25 to reflect the current dietary order.
- The administrator will audit all other resident support plans by 9/30/25 ensure current and appropriate supports are reflected.
- Beginning no later than 9/30/25, the administrator will audit all resident support plans quarterly to ensure supports remain current and accurate.
- Documentation of completed audits and updated support plans will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [redacted] - 10/28/2025)

251b - Record Entries Legible

68. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident #3's preadmission screening, changing the "date screening completed".

Correction fluid was used on resident #4's medical evaluation, dated [redacted]/24, covering medical diagnoses and medical information pertinent to diagnosis and treatment in case of an emergency.

Plan of Correction

Directed [redacted] - 09/19/2025)

the administrator used correction fluid on several documents just to cover writing mistakes not to conceal any wrong doings.

however, moving forward and effective immediately the administrator will not use any correction fluid on any documents. the administrator will simply correct any mistakes with one line going across the mistake and then initial and date the mistake. nothing more will be done to documents for any mistakes made on them other than using a single line. no staff has ever used correction fluid but to further avoid any future mishaps, the administrator will include this topic in the upcoming staff meeting on 9/8/2025 to ensure all staff understand the severity of this act. the administrator will be responsible for reviewing all documents at least weekly to ensure no correction fluid is being used

(Directed)

- The administrator will be educated on 2600.251(b) by 9/30/25.
- Beginning no later than 9/30/25, the administrator will be responsible for reviewing all documents at least weekly to ensure no correction fluid is being used.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Not Implemented [redacted] - 10/28/2025)

251c - Standardized Forms

69. Requirements

2600.

251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident #5's medical evaluation, dated [REDACTED]/25, was not completed on the Department's current standardized form.

Plan of Correction

Directed [REDACTED] - 09/19/2025)

unfortunately, the administrator was unaware of the current DME form that was effective July 1, 2025, the administrator missed the memo of the change.

effective immediately the administrator will be sure to double check emails from DHS to make sure all-important updates are not missed. the administrator will effective immediately and continuing ongoing, check emails specifically from DHS daily and will again thoroughly check every week on Tuesdays and will be sure to follow all updates and changes pertaining to PCH

since the inspection, the inspector sent the administrator the new DME form, and the administrator has printed the new form out and has placed it in the admission "original form packet" to ensure that the new form will be utilized effective immediately. the old DME form has be thrown away and will not be used moving forward effective immediately.

the administrator has also requested resident's 5 DME information be completed on the new DME so that the information can be in compliance. the administrator will follow up with resident's 5 PCP to make sure that this is completed. the administrator will check weekly beginning on Thursday 9/4/2025 and will continue until received. once received the administrator will immediately review for accuracy and completion then file the new DME in the resident's 5 file

if any issues with the information on the DME the administrator will contact the PCP and request for the information to be corrected and then begin weekly checks until received

(Directed)

In addition to the above plan of correction,

- The administrator will have resident #1's most recent medical evaluation completed on the correct form by 9/30/25.*
- The administrator will complete an audit of all other resident medical evaluations to ensure the use of the proper form by 9/30/25.*
- Documentation of completed audits and communication with the physician will be kept by the home and available for review by the Department.*

Directed Completion Date: 09/30/2025

Implemented ([REDACTED] - 10/28/2025)

254c - Records Storing

70. Requirements

2600.

254.c. Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

Description of Violation

On 7/15/25, resident records were stored in a locked area within the home and inaccessible to the administrator's

254c - Records Storing (continued)

designee and to the Department.

Plan of Correction

Directed [REDACTED] - 09/19/2025)

on 7/15/25 the administrator was leaving the home to go to [REDACTED], moving fast, the administrator unconsciously took the key to the file cabinet. upon return, the administrator allowed the agent access to the file cabinet which was storing the residents record.

on 7/16/25, as observed by the inspector, the key to the office was placed back on the staff key ring where they are usually placed. on 7/14, just the day before the inspection, the administrator took the keys (basement and office, because they are on the same ring) off the staff key ring to make a copy due to a recent lockout but was not able to be relieved from work before the stores closed, and forgot to put the keys back on the ring, instead, they were in the administrator's purse that was worn to her aunt's funeral the day of the inspection.

moving forward and effectively immediately, the administrator, as well as all PCA staff, shall check the staff key ring for all eight keys that are supposed to be on the key ring (staff bathroom, two med cart keys, office, basement door, pharmacy box in the refrigerator, paper towel and toilet paper dispensary keys) at least one time during each staff member's shift. if any key(s) are missing, staff will report to the administrator immediately via text, call or face to face. the administrator will be responsible for investigating how the key was lost and then request payment from the responsible staff for a new key, doorknob, service and labor cost if the key cannot be found within 3 hours (and one business day if the staff bathroom, toilet paper or paper towel holder keys are missing). if the responsible staff cannot pay on site, the administrator will deduct the total cost out of the staff's upcoming check. this rule goes for all staff including the administrator. the administrator will be responsible for calling a lock smith at 3 hours missing.

by the end of the year, the administrator plans to replace all doorknobs in the entire home. the administrator plans to paint all doors to enhance the home's aesthetics of the home and to replace locks to further prevent any doors from being locked unwantedly and also to enhance the home's appearance. the administrator will discuss the staff's responsible for the staff key ring at the staff meeting on 9/8/2025

(Directed)

In addition to the above plan of correction:

- The administrator will make spare copies of each key needed to access areas of the home to ensure resident records are stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.
- Daily audits of the keys will begin no later than 9/30/25
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 09/30/2025

Implemented [REDACTED] - 10/28/2025)

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

Facility Information

Name: *FAMILY CARES PERSONAL CARE HOME* License #: *33794* License Expiration: *12/19/2025*
Address: *101 SOUTH BROAD STREET, NEW FREEDOM, PA 17349*
County: *YORK* Region: *CENTRAL*

Administrator

Name: [REDACTED]

Legal Entity

Name: *FAMILY CARES LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *11/01/2004* Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *13* Waking Staff: *10*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Interim* Exit Conference Date: *10/14/2025*

Inspection Dates and Department Representative

10/08/2025 - On-Site: [REDACTED]
10/09/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *17* Residents Served: *12*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *12* Are 60 Years of Age or Older: *12*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *1* Have Physical Disability: *1*

Inspections / Reviews

10/08/2025 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *Bypass Document Submission*

11/13/2025 - Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: *11/13/2025*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

25a - Written Contract and Review

1. Requirements

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident’s designated person if any, prior to signature.

Description of Violation

Resident #1, admitted [REDACTED]/25, did not have a resident-home contract completed.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] 11/10/2025)

- The administrator will complete and review a resident-home contract with Resident #1 by 12/12/25 and file the signed contract in the resident's record.
- The administrator will complete an initial audit of all other resident contracts to ensure they are signed and filed in the resident record by 12/12/25.
- Beginning no later than 12/12/5, the administrator will ensure contracts for all new admissions are reviewed and signed by the resident moving into the home by completing an audit of each new contract within 24 hours of the resident residing in the home.
- Documentation of completed contracts and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

41a - Complaint w/o Retaliation

2. Requirements

2600.

41.a. Upon admission, each resident and, if applicable, the resident’s designated person, shall be informed of resident rights and the right to lodge complaints without intimidation, retaliation, or threats of retaliation of the home or its staff persons against the reporter. Retaliation includes discharge or transfer from the home.

Description of Violation

Resident #1, admitted on [REDACTED]/25, was not informed of their resident rights and the right to lodge complaints without intimidation, retaliation or threats of retaliation of the home or staff.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The administrator will receive education on regulation 2600.41(a) by 12/12/25.
- Resident #1 will be informed of resident rights and the right to lodge complaints without intimidation, retaliation, or threats of retaliation of the home or its staff persons against the reporter by the administrator by 12/12/25.
- The administrator will review the home's current resident-home contract and update the document to include the process of reviewing the resident's right in the contract by 12/12/25 if it is not already identified.
- Beginning no later than 12/12/25, upon admission, each resident, and if applicable, the resident's designated contact will be informed of the resident's rights and the right to lodge complaints without intimidation, retaliation, or threats of retaliation of the home or its staff persons against the reporter.
- Beginning no later than 12/12/5, the administrator will ensure contracts for all new admissions are reviewed and signed by the resident moving into the home by completing an audit of each new contract within 24

41a - Complaint w/o Retaliation (continued)

hours of the resident residing in the home.

Directed Completion Date: 12/12/2025

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 member A's first day of work was [REDACTED]/25; however, their Pennsylvania criminal history background check was not requested until 9/30/25.

Staff member B's date of hire was [REDACTED]/25; however, their Pennsylvania criminal history background check was not requested until 10/8/25.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The administrator will receive education on Criminal Background Checks and the Older Adult Protective Services Act by 12/12/25.
- A new staff member document tracking system will be developed and implemented by the administrator to ensure and track all new hire's required documentation by 12/12/25.
- Beginning 12/12/25, the administrator will complete an audit of all newly hired staff background checks within 24 hours of the staff member's first day of work to ensure all employees have a Pennsylvania State Police Criminal Background Check as well as a report of federal criminal history record information from the Federal Bureau of Investigation, as applicable.
- Documentation of education and completed audits will be kept by the home and available for review by the Department

Directed Completion Date: 12/12/2025

60a - Staff/Support Plan**4. Requirements**

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Staff Member A, who has not completed the Department-approved medication administration training, worked alone in the home on 10/1/25 and 10/6/25 from 3:00 PM until 9:00 PM. Residents in the home have regularly scheduled medications during this time including:

Resident #2-5:00 PM-Hydralazine 50mg

Resident #3-5:00 PM-Omega 3 Acid 1 GM; 7:00 PM- Warfarin Sodium 3mg and Simvastatin 40mg

60a - Staff/Support Plan (continued)

Resident #4-7:00 PM- Atorvastatin 40mg, Gabapentin 100mg, Melatonin 3mg, and Metoprolol Tartrate 25mg.

Repeated Violation - 11/21/24 and 7/9/24, et al.

Plan of Correction**Directed (█) - 11/12/2025)**

- The administrator will complete an initial audit of all other staff in the home to ensure they have completed the Department approved medication administration course and all required medication observations and MAR reviews are filed in the staff members' records by 12/12/25.
- Beginning no later than 12/12/25, the administrator will review the staff schedule at least one week in advance to ensure a staff member certified in medication administration is scheduled each shift.
- All staff will receive education on the requirement for at least one staff member to be present in the home who is certified in medication administration at all times. The administrator will receive notification of any call-offs from staff to ensure a staff member certified in medication administration will cover the shift. Education will be provided by the administrator by 12/12/25.
- Documentation if completed education, initial audit and staff schedules will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

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 Members B and C, whose first day of work was 10/2/25, and 10/3/25 respectively, did not receive orientation on any of the training topics as specified in 2600.65(a).

Plan of Correction**Directed (█) - 11/12/2025)**

- The administrator will receive education on regulation 2600.65(a) by 12/12/25.
- Staff Members B and C will receive education in general fire safety and emergency preparedness in accordance with regulation 2600.65(a) by 12/12/25.
- By 12/12/25, the administrator will review all other current staff person training records to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in general fire safety and emergency preparedness in accordance with regulation 2600.65(a). Any staff identified as not having received the required training will be provided with the education by 12/12/25.
- By 12/12/25, the administrator will develop and implement a new hire document to track all required staff documentation and training. The administrator will review the document by the end of the staff member's

65a - FS Orientation 1st Day (continued)

first day of hire to ensure required training has been completed.

- *Documentation of completed education, audits and new hire documents will be kept in the home and available for review by the Department.*

Directed Completion Date: 12/12/2025

82c - Locking Poisonous Materials**6. Requirements**

2600.

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

Description of Violation

On 10/8/25, the following materials were unlocked, unattended and accessible to residents in the home:

- *Sheetrock All Purpose Joint Compound with a manufacture's label indicating to get medical attention if contact causes irritation; located in the hallway closet.*
- *2 gallons of paint and 1 pint of paint with a manufacturer's label indicating to get medical attention immediately if swallowed; located in the hallway closet.*
- *Great Value Toilet Bowl Cleaner with Bleach with a manufacturer's label indicating if swallowed call poison control center or doctor immediately; located in Resident #5's bathroom.*
- *Great Value Multi-Purpose Cleaner with a manufacturer's label indicating to call a poison control center or doctor immediately for treatment advice; located in Resident #5's bathroom.*
- *Comet with Bleach with a manufacturer's label indicating, if swallowed call physician or poison control center; located in Resident #5's bathroom.*

Not all residents in the home are assessed capable of recognizing and using poisons safely including Residents #5 and #9.

Plan of Correction

Directed [REDACTED] **- 11/12/2025)**

- *The administrator will complete an initial audit in the home to ensure poisonous materials are kept locked and inaccessible to residents by 12/12/25.*
- *All staff persons will be educated concerning the safe storage of poisonous materials and the risks to residents by 12/12/25.*
- *Beginning 12/12/25, a designated staff person will check the home daily on each shift to ensure poisonous materials are not accessible to residents.*
- *Beginning 12/12/25, the administrator will monitor the home weekly to ensure poisonous materials are not accessible to residents.*
- *Documentation of completed education and audits will be kept in the home and available for review by the Department.*

Directed Completion Date: 12/12/2025

85a - Sanitary Conditions

7. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/9/25 at approximately 9:30 AM, Resident #6's bedroom had an odor of urine.

Repeated Violation - 7/9/24, et al.

Plan of Correction**Directed [REDACTED] - 11/12/2025)**

- The administrator or designated staff member will thoroughly clean Resident #6's bedroom by 12/12/25.*
- Education will be provided to all staff in the home on regulation 2600.85(a) by 12/12/25.*
- Beginning 12/12/25, the administrator or designated staff member will complete daily audits of Resident #6's bedroom to ensure there is no pungent odors present.*
- Documentation of education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: 12/12/2025

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

On 10/8/25 at 9:05 AM, water was actively dripping from the ceiling in the staff office. An area of the ceiling, measuring approximately 3' by 1.5', had bubbling paint and a long crack exposing wood above the damaged surface.

On 10/8/25 at 9:25 AM, two exhaust vents in the communal bathroom near resident room 4 was covered in a layer of dust with the potential to prevent proper ventilation.

On 10/8/25 at 9:26 AM, the ceiling return vent in the hallway near the staff office was covered in approximately a 1/2" thick layer of dust with the potential to prevent proper air flow to the home's main heating and cooling units.

Plan of Correction**Directed [REDACTED] - 11/12/2025)**

- The leak and damaged surface of the ceiling located in the staff office will be repaired no later than 12/12/25.*
- The exhaust vents in the communal bathroom and ceiling return vent in the hallway will be cleaned by 12/12/25.*
- The administrator will audit all other floors, walls, ceilings, windows, doors and other surfaces to ensure they are clean, in good repair and free of hazards by 12/12/25. The audit will include findings and a plan to correct each area needing to be cleaned and/or repaired.*
- Education will be provided to all staff members in the home on regulation 2600.88(a) and reporting areas in the home found to be in need of cleaning or repair by 12/12/25.*
- Beginning no later than 12/12/25, the administrator will complete weekly audits of the home. Any area identified will be cleaned or repaired within 1 week or sooner if hazardous conditions are identified.*
- Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: 12/12/2025

101o - Walls, Floors, Ceilings

9. Requirements

2600.

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

Description of Violation

The ceiling in resident room 12 had two ceiling vents missing, leaving two holes measuring at least 10 inches by 4 inches.

Plan of Correction

Directed (█ - 11/12/2025)

- *The missing ceiling vents in resident room 12 will be replaced and/or the administrator will have the holes repaired by 12/12/25.*
- *Education will be provided to all staff on regulation 2600.101(o) by 12/12/25.*
- *By 12/12/25, the administrator will complete an audit on all other resident bedrooms to ensure each bedroom has walls, floors and ceilings which are finished, clean and in good repair. The audit will include findings and a plan to correct each area needing to be cleaned and/or repaired.*
- *Beginning no later than 12/12/25, the administrator will complete weekly audits of resident bedrooms. Any area identified will be cleaned or repaired within 1 week or sooner if hazardous conditions are identified.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: 12/12/2025

121a - Unobstructed Egress

10. 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 10/8/25 at 9:12 AM, a sliding latch was affixed to the inside of the door by the laundry/kitchen/medication area, blocking the immediate egress path from the front of the home to the rear exit.

Plan of Correction

Directed (█ - 11/12/2025)

- *The administrator will remove the sliding latch that is affixed to the inside of the door by the laundry/kitchen/medication area, blocking the immediate egress path from the front of the home to the rear exit by 12/12/25.*
- *Beginning 12/12/25, the administrator or designee will inspect the home each shift to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed.*
- *The administrator will provide education to all staff regarding the requirement that all stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed by 12/12/25.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

121a - Unobstructed Egress (continued)

Directed Completion Date: 12/12/2025

123c - Evacuation Diagrams

11. Requirements

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 12 residents. However, there are no emergency evacuation diagrams posted that show the location of the fire extinguishers or pull signals.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- Fire extinguishers and pull signals will be added to the evacuation diagrams by the administrator by 12/12/25.
- Beginning 12/12/25, the administrator will monitor the evacuation diagrams weekly for 4 weeks and then monthly thereafter.
- Documentation of completed initial and on-going audits will be kept by the home.

Directed Completion Date: 12/12/2025

125b - Combustible Restrictions

12. Requirements

2600.

125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On 10/8/25, engine oil, lighter fluid, and gasoline located in the storage shed and grill were unlocked, unattended, and accessible to residents.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] /12/2025)

- All combustible materials will be moved and secured in a locked area that is inaccessible to residents by 12/12/25.
- The administrator will educate staff to always keep combustible and flammable materials in an area that is not accessible to residents by 12/12/25.
- Beginning 12/12/25, the administrator will complete weekly audits of the home to ensure combustible materials are inaccessible to residents for 4 weeks and then monthly thereafter.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

125b - Combustible Restrictions (continued)

Directed Completion Date: 12/12/2025

127a - Portable Space Heaters

13. Requirements

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

On 10/8/25 at 9:30 AM, two portable space heaters were located in the shed.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- All portable space heaters will be removed from the home by 12/12/25.
- Education will be provided to all staff on regulation 2600.127(a) by the administrator by 12/12/25.
- The administrator will complete a weekly walkthrough of the home to ensure there are no portable space heaters stored on the property.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

130d - Interconnected Detectors

14. Requirements

2600.

130.d. If the home serves nine or more residents, there shall be at least one smoke detector on each floor interconnected and audible throughout the home or an automatic fire alarm system that is interconnected and audible throughout the home.

Description of Violation

On 10/9/25, the home served 12 residents. The interconnected smoke detector located in the basement's kitchen was not functional as the battery had been pulled from the device by the administrator in order to disable the alarm.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The administrator will have the smoke detector(s) located in the basement kitchen replaced with a smoke detector that is interconnected and audible throughout the home by 12/12/25.
- Education will be provided to the administrator and all staff on regulation 2600.130(d) by 12/12/25.
- Beginning 12/12/25, the administrator will complete monthly audits of the home's smoke detector(s) on each floor to ensure they are interconnected and audible throughout the home.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

130d - Interconnected Detectors (continued)

Directed Completion Date: 12/12/2025

131a - Fire Extinguisher

15. Requirements

2600.

131.a. There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

Description of Violation

On 10/9/25 at 11:57 AM, the fire extinguisher located in the basement kitchen was inoperable as it was overcharged.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The administrator will contact the fire extinguisher servicing company by 12/12/25 regarding the overcharged fire extinguisher located in the basement. Documentation of communication and service repair will be kept by the home and available for review by the Department.
- Beginning 12/12/25, all fire extinguishers will be checked monthly by the administrator in conjunction with the monthly fire drill to ensure they are present and operable. Documentation of audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

132g - Fire Drills Days/Times

16. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

In September 2025, the home routinely had only one staff member working on each shift. On 9/14/25, only one staff member was on shift from 3:00 PM until 7:00 AM the next morning. However, on 9/14/25 at 6:07 PM a fire drill was held in the home with two staff members participating in the drill.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The administrator and any staff involved in conducting fire drills will review the fire drill regulations and additional information regarding Fire Drills and Evacuation within the Regulatory Compliance Guide for Chapter 2600 regulations by 12/12/25. Documentation of the education will be kept and made available to the Department for review.
- Beginning 12/12/25, the monthly fire drills will be conducted with only the routinely scheduled staff member's assisting the evacuation of residents. The administrator, who is observing the fire drill, will not assist with the fire drill evacuation process unless another designated administrator is scheduled to observe the drill.
- If a fire drill is held with more staff members than is routinely scheduled, then a second fire drill will be completed within 5 days.
- Documentation of education and completed fire drills will be kept by the home and available for review by the Department.

132g - Fire Drills Days/Times (continued)

Directed Completion Date: 12/12/2025

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

The medical evaluation was not complete within 60 days prior to admission or within 30 days after Resident #1's admission to the home. Resident #1 was admitted on [REDACTED] 25; however, the resident's medical evaluation was completed on [REDACTED]/25.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- Resident #1 will have an updated medical evaluation completed by 12/12/25 to ensure the resident's medical needs can be met at the home.
- Education will be provided to the administrator on regulation 2600.141(a) by 12/12/25.
- The administrator will review all current resident records to ensure each resident has had an in-person medical evaluation within the required timeline of admission.
- Beginning 12/12/25, the administrator will review all new resident documentation to ensure all new residents have an in-person medical evaluation completed within 60 days prior to admission or within 30 days after admission within 5 days of a resident moving into the home.
- Documentation of education and resident record audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

141b1 - Annual Medical Evaluation

18. Requirements

2600.

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

Description of Violation

Resident #7's most recent medical evaluation, completed on [REDACTED]/24, reads, the resident can self-administer some medications but not others, see attached; however, a full list of their medications and the frequency to administer them, or a list of medications they can self-administer was not attached.

Repeated Violation - 7/9/24, et al.

141b1 - Annual Medical Evaluation (continued)

Plan of Correction**Directed (█ - 11/12/2025)**

- The administrator will contact Resident #7's physician by 12/12/25 to obtain a physician's order specifying the medications resident #7 is capable of self-administering. The physician's order will be filed in the resident's record.
- All staff persons involved with the medical evaluation process will be educated on the required contents of the medical evaluation by 12/12/25.
- The administrator will review all current medical evaluations to ensure that all required information is completed, including medication lists. Incomplete medical evaluations will be returned to the physician for completion or new medical evaluations will be scheduled by 12/12/25.
- Beginning 12/12/25, the administrator will review a resident's medical evaluation within 24 hours of completion to ensure the medical evaluation is completed properly and thoroughly. Incomplete medical evaluations will be returned to the physician for completion or new medical evaluations will be scheduled.

Directed Completion Date: 12/12/2025

142d - Secure Preventative Care

19. Requirements

2600.

142.d. The home shall assist the resident to secure preventative medical, dental, vision and behavioral health care as requested by a physician, physician's assistant or certified registered nurse practitioner.

Description of Violation

Resident #7's assessment, completed on █/24, indicated the resident requires prompting and cueing with overall health care coordination such as tracking different doctors' appointments and medications. Resident #7 has not been assessed capable to independently change her Dexcom sensor or monitor █ blood glucose levels. On 10/9/25, Resident #7 reported that █ sensor has not been transmitting █ blood glucose levels to the meter since 10/7/25. The home has not assisted Resident #7 in monitoring █ blood glucose levels daily or Dexcom sensor to ensure it is operating properly.

Plan of Correction**Directed (█ - 11/12/2025)**

- Resident #7 will be assessed by a physician to determine if the resident is capable of independently changing her Dexcom sensor and monitor blood glucose levels by 12/12/25. If the resident is not capable of independently applying/changing her Dexcom sensor, then the home will provide assistance as needed.
- The administrator will develop a policy or procedure on assisting residents with Dexcom sensors. Education on the developed procedure will be provided to all staff certified in diabetic education on assisting residents with Dexcom sensors including checking the Dexcom sensor is positioned correctly, properly obtaining blood glucose levels, changing Dexcom sensors and when to notify the physician if a Dexcom is not functioning. All staff will receive education on the home's procedures by 12/12/25.

Directed Completion Date: 12/12/2025

144c1 - Smoking Area Guidelines

20. Requirements

2600.

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

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home does not permit smoking on the property. On 10/8/25, a metal container located next to the ramp on the side egress of the home was full of cigarette butts.

Plan of Correction**Directed (█ - 11/12/2025)**

- *The administrator will provide education to all residents and staff in the home on the home's smoking policy which indicates the home does not permit smoking on the property by 12/12/25.*
- *The metal container located by the ramp will be discarded by 12/12/25.*
- *The administrator will complete monthly audits of the home beginning 12/12/25 to ensure staff and residents are not smoking on the property.*
- *If the administrator chooses to permit smoking on the property, the home's smoking policy will be revised and will include requirements as identified in regulation 2600.144(c); staff and residents will be educated on the updated policy.*

Directed Completion Date: 12/12/2025

161d - Dietary Needs**21. Requirements**

2600.

161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

On 7/2/25, Resident #2 was prescribed an adult diet, modified, easy to chew, level 7, heart healthy diet. According to the International Dysphagia Diet Standardisation Initiative (IDDSI), foods to avoid when following an easy to chew, level 7 diet are: tough or fibrous foods, chewy foods, and meat with gristle. Foods to consume on this diet must be able to be smashed with a fork, leaving the food completely squashed and not regaining its shape. However, on 10/8/25 at noon, Staff Member D served Resident #2 hot dogs cut into approximately 1 inch pieces. Resident #2 reported difficulty in consuming the hot dogs in the meal.

Plan of Correction**Directed (█ - 11/12/2025)**

- *The administrator will check all resident current medical evaluations, discharge orders, any physician orders and other pertinent documentation to determine residents' special dietary needs by 12/12/25.*
- *The administrator and all staff involved in food preparation and serving will receive education from a registered dietitian regarding the preparation of food for all residents with special dietary needs by 12/12/25.*
- *Beginning 12/12/25, the administrator, in consultation with a registered dietitian, will develop a monthly menu to ensure residents' special dietary needs are being met including mechanically altered diets.*
- *Beginning 12/12/25, the administrator will monitor the menu, food supply, food preparation and food serving, at least once on a weekly basis to ensure residents' special dietary needs are being met.*

161d - Dietary Needs (continued)

- *By 12/12/25, the administrator will develop and implement a policy and procedure that confidentially communicates any special dietary needs to all staff persons including all staff that prepares meals. All staff persons involved in food preparation and serving will be educated on the home's policy and procedure that confidentially communicates any special dietary needs to all staff persons including all staff that prepares meals.*
- *Documentation of education and mealtime observations/monitoring will be kept by the home and available for review by the Department.*

Directed Completion Date: 12/12/2025

162c - Menus Posted**22. Requirements**

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 10/8/25, the menu for the current week of 10/5/25-10/11/25 and a menu for 1 week in advance were not posted in the home.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed (█ - 11/12/2025)

- *The administrator and all staff in the home will receive education on regulation 2600.162(c) by 12/12/25.*
- *Beginning 12/12/25, the administrator will create a current weekly menu and a menu for the following week and post them in a public place in the home.*
- *Beginning 12/12/25, the administrator will complete weekly audits in the home to ensure the menu for the current week is posted as well as a menu for 1 week in advance.*
- *Documentation of completed education and audits will be kept by the home and available for review by the home.*

Directed Completion Date: 12/12/2025

183b - Meds and Syringes Locked**23. Requirements**

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 10/8/25 at 12:00 PM, two, 300mg Gabapentin tablets were unlocked, unattended, and accessible in the trash can next to the medication cart.

On 10/9/25 at 9:22 AM, an unlabeled bottle of Eye Relief Dry Eyes drops was unlocked, unattended, and accessible

183b - Meds and Syringes Locked (continued)

sitting on a dresser in bedroom 1 A/B.

On 10/9/25 at 9:47 AM, Antifungal Powder with Miconazole Nitrate 2% was unlocked, unattended, and accessible on a dresser in Resident #7's bedroom.

Plan of Correction**Directed [REDACTED] - 11/12/2025)**

- The administrator will complete an audit of the home by 12/12/25 to ensure all other medications are kept in an area or container that is locked. The audit will include the results and the plan of action to correct the initial findings.
- The administrator will provide education to all staff and residents on regulation 2600.183(b) by 12/12/25.
- Staff in the home will also receive education on how to properly discard medication in the home by 12/12/25 to ensure medications are not disposed of by placing them in the trash bin in the home.
- Beginning no later than 12/12/25, the administrator will complete weekly audits in the home to ensure medications remain kept in an area or container that is locked.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

183d - Prescription Current**24. 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

On 10/8/25, Gabapentin 100mg, take by mouth twice daily prescribed, for Resident #4, was in the home's medication cart; however, the medication was discontinued on 10/6/25.

On 10/8/25, Diclofenac Sodium gel, prescribed for Resident #4, was located in the home's medication cart; however, the resident does not have a current order for this medication.

Repeated Violation - 7/9/24, et al.

Plan of Correction**Directed [REDACTED] - 11/12/2025)**

- The medications identified for Resident #4 will be discarded or destroyed by the administrator by 12/12/25.
- The administrator and all staff will be educated on regulation 2600.183(d) by 12/12/25.
- The administrator will complete an initial audit of all medications in the home by 12/12/25 to ensure only current prescription, OTC, sample and CAM for individuals residing in the home are kept in the home.
- Beginning no later than 12/12/25, the administrator will complete weekly audits of medications in the home to ensure only current prescription, OTC, sample and CAM for individuals residing in the home are kept in the home.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

183e - Storing Medications

25. 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

On 10/8/25, two bottles of Latanoprost .005% eye drops for Resident #8 were open and in use, but not dated for when they were opened. According to the manufacturer's instructions, once opened, use within 6 weeks.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- Resident #8's Latanoprost will be discarded by 12/12/25 and a new bottle will be opened and dated.
- The administrator will review and update the policy and procedures for the safe and secure storage of medications and controlled substances, including that all medications are properly dated and stored per the manufacturer's instructions. Education to all staff who administer medications will be completed on the updated policy and procedure by 12/12/25.
- Beginning 12/12/25, the administrator or designee will complete weekly audits of the home's medications to ensure medications are dated and stored per the manufacturer's instructions.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

183f - Discontinued Medications

26. Requirements

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On 10/8/25, at 12:00 PM, two tablets of Gabapentin 300mg belonging to Resident #4 were disposed of by placing the tablets in a trashcan next to the home's medication cart. This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The home's administrator and all staff persons administering medications will be re-educated on the requirements of regulation 2600.183(f) including destroying medications a safe manner according to the Department of Environmental Protection and Federal and State regulations by 12/12/25.
- The administrator will review and update the home's policy and procedures on medication administration

183f - Discontinued Medications (continued)

to include the proper destruction of medications in the home. Staff will receive education on the updated policy by 12/12/25.

- Beginning 12/12/25, the administrator will observe and interview staff at least once weekly for four weeks on the medication destruction process to ensure resident medications are being disposed of/destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

184a - Resident's Meds Labeled**27. Requirements**

2600.

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

1. The resident's name.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #4 is prescribed Tramadol 50mg, 1 tablet every 8 hours as needed for severe pain for up to 14 days. On 10/8/25, the pharmacy label indicated to take 1 tablet orally every 8 hours as needed for severe pain up to 3 days.

On 10/8/25 at 11:32 AM, a Lantus Solostar insulin pen, prescribed to Resident #7, was not labeled with the resident's name or the instructions for administration.

On 10/8/25 at 11:32 AM, two boxes of Eliquis 5mg belonging to Resident #9 were in the home's medication cart and not labeled with a pharmacy label or information that included the prescribed dosage and instructions for administration, or the name of the prescriber.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The administrator will reach out to pharmacy to obtain correct labels for Residents #4, #7 and #9 medications by 12/12/25.
- The administrator will complete an initial audit by 12/12/25 on all resident medication and physician orders to ensure the original container for prescription medications are labeled with a pharmacy label in accordance with regulation 2600.184(a).
- The administrator and all staff who administer medications will receive education on regulation 2600.184(a) by 12/12/25.
- Beginning no later than 12/12/25, the administrator will complete weekly audits for 4 weeks and then monthly thereafter to ensure the original container for prescription medications shall be labeled with a pharmacy label in accordance with regulation 2600.184(a).
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

184a - Resident's Meds Labeled *(continued)*

Directed Completion Date: 12/12/2025

184b - Labeling OTC/CAM

28. Requirements

2600.

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

Description of Violation

On 10/8/25, a bottle of Antacid 750mg tablets was in the top drawer of the home's as-needed medication cart and was not labeled with the resident's name. Staff Member D was unable to identify to whom the medication belonged.

On 10/9/25, a bottle of Eye Relief drops was sitting on a dresser in bedroom 1 A/B and not labeled with the resident's name. Staff Member D was unable to identify to whom the medication belonged.

Repeated Violation - 11/21/24 and 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- *The administrator will label the identified medications with the resident's name by 12/12/25. If the resident the medications belong to cannot be identified, the medications will be discarded or disposed of by the administrator by 12/12/25.*
- *The Administrator will complete an initial audit on all over the counter medications by 12/12/25 to ensure they are identified with the resident's name(s).*
- *Education will be provided to all staff who administer medications, including the administrator, on regulation 2600.184(b) by 12/12/25.*
- *Beginning no later than 12/12/25, the administrator will complete weekly audits for 4 weeks and then monthly thereafter to ensure OTC medications belonging to the resident, are identified with the resident's name in accordance with regulation 2600.184a.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: 12/12/2025

185a - Implement Storage Procedures

29. 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 home's Medication Administration Policy indicated, outdated, discontinued, contaminated, or soiled medications will be stored in a locked disposal box while awaiting disposal. The staff will fill out the Medication Disposal Form indicating the name of the medication, the quantity, the reason for disposal, the method and the date. The staff must sign the form and store it in the locked box with the medications. On a weekly or as needed basis, the Administrator, will take disposed medications to a local police station. The home's policy has not been implemented and does not document the disposal or destruction of medications as follows:

- *Staff Member D, [REDACTED], reported the home has "gotten rid of a lot of medications" since*

185a - Implement Storage Procedures (continued)

July 2025 and has not recorded the disposal or destruction on a Medical Disposal Form.

- On 10/8/25, Staff Member D disposed of two Gabapentin 300mg tablets, belonging to Resident #4, by placing the tablets in the trash can next to the medication cart; Staff Member D did not record the disposal or destruction information.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The administrator will review and update the home's medication administration policy and make updates as needed regarding the medication destruction/disposal procedure. All staff will receive education on the updated policy by 12/12/25.
- Beginning 12/12/25, the administrator will review all required medication destruction documentation monthly and complete medication cart audits to ensure any missing medications from the medication cart have been properly documented in the medication destruction log, as applicable.
- Documentation of completed education and audits will be kept in the home and available for review by the Department.

Directed Completion Date: 12/12/2025

187a - Medication Record

30. Requirements

2600.

- 187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
3. Name of medication.
 4. Strength.
 5. Dosage form.
 6. Dose.
 7. Route of administration.
 8. Frequency of administration.
 9. Administration times.
 12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

On 10/2/25, Resident #4 was ordered Loperamide 2mg, take 4 times a day as needed for up to 10 days. Staff Member D administered this medication twice to Resident #4 in October 2025; however, this medication is not documented on Resident #4's October 2025 Medication Administration Record.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- Resident #4's Medication Administration Record (MAR) will be updated to include the prescribed Loperamide by 12/12/25 in accordance with regulation 2600.187(a).
- The administrator and all staff will receive education on regulation 2600.187(a) by 12/12/25.

187a - Medication Record (continued)

- *The administrator will complete an initial audit on all resident MAR's by 12/12/25 to ensure all prescribed medications are documented on the MAR's in accordance with regulation 2600.187(a).*
- *Beginning 12/12/25, the administrator will complete weekly audits on all resident MAR's for 4 weeks and then monthly thereafter to ensure all prescribed medications are documented on the resident's MAR's in accordance with regulation 2600.187(a).*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: 12/12/2025

187b - Date/Time of Medication Admin.**31. 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 #1 is prescribed Indomethacin 25mg, take 1 capsule by mouth twice a day. Resident #1's October 2025 Medication Administration Record (MAR) does not include the initials of the staff person who administered the medication on 10/7/25 at 7:00 PM.

Resident #4 was administered the following medications by Staff Member D; however, Staff Member D did not document the administration of the medications on Resident #4's October 2025 MAR until 10/8/25.

- *Midodrine HCL 10mg-administered on 10/7/25 at 7:00 AM and 12:00 PM.*
- *Omeprazole 20mg-administered on 10/8/25 at 7:00 AM.*
- *Pentoxifylline ER 300mg - administered on 10/7/25 at 7:00 AM, 12:00 PM and 5:00 PM.*
- *Tamsulosin 0.4mg-administered on 10/7/25 at 7:00 AM.*
- *Tiotropium 18mcg-adminisntered on 10/7/25 at 7:00 AM.*

Plan of Correction

Directed [REDACTED] **- 11/12/2025)**

- *All staff persons qualified to administer medications, including the administrator, will be educated on the proper procedures for medication administration including documentation of medication administration at the time of administration by 12/12/25.*
- *The administrator will check all resident's MARs at least weekly to ensure the proper documentation of medication administration at the time of administration beginning 12/12/25.*
- *Documentation of completed education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: 12/12/2025

187d - Follow Prescriber's Orders**32. Requirements**

2600.

187d - Follow Prescriber's Orders (continued)

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

Description of Violation

Resident #4 is prescribed Furosemide 20mg tablet, take 1 tablet by mouth once daily for fluid retention. On 9/30/25, Resident #4's physician reported the resident was dizzy and had a blood pressure of 72/50. The physician ordered a hold for the administration of Resident #4's Furosemide 20mg for several days to see if it helps with blood pressure and dizziness. However, Resident #4 was administered Furosemide 20mg on 10/1/25, 10/2/25, and 10/3/25 at 7:00 AM.

Resident #4 is prescribed Metoprolol Tartrate 25mg, take half tablet twice a day and hold for systolic blood pressure less than 100. From 10/1/25 through 10/8/25, Resident #4's blood pressure was not monitored by the home and the medication was not administered.

On 10/6/25, Resident #4 received an order to discontinue Gabapentin 100mg twice daily and received a new order to start Gabapentin 300mg, take twice daily. This medication was not administered to Resident #4 on 10/6/25 at 7:00 PM, 10/7/25 at 7:00 AM and 7:00 PM, or 10/8/25 at 7:00 AM.

Resident #4 is prescribed Albuterol HFA 90mcg, inhale 2 puffs by mouth every 4 hours. This medication was not administered to Resident #4 from 10/1/25 through 10/7/25 as Staff Member D, [REDACTED], indicated [REDACTED] did not know the medication was ordered as daily administration.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The administrator will report and document Resident #4's medication errors in accordance with regulation 2600.188 by 12/12/25..
- The administrator will report the medication errors for Resident #4 to the Department in accordance with regulation 2600.16(c) by 12/12/25.
- All staff persons qualified to administer medications, including the administrator, will be educated on the proper procedures for medication administration including following the prescriber's orders and documentation by 12/12/25.
- The administrator will observe medication administration at least twice a week and audit all resident MAR's at least once weekly for 3 months to ensure all resident medications are administered as prescribed beginning 12/12/25.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

190a - Completion Medication Course

33. Requirements

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff member A, who has not completed the Department-approved medication administration course, administered medications as follows:

190a - Completion Medication Course (continued)

On 10/1/25 and 10/6/25 at 5:00 PM-Hydralazine 50mg to Resident #2,
On 10/6/25 at 5:00 PM-Omega-3 Acid 1gm and Warfarin Sodium 4mg to Resident #3,
On 10/1/25 and 10/6/25 at 7:00 PM-Gabapentin 100mg, Melatonin 3mg, and Atorvastatin 40mg to Resident #4.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- Staff Member A will not administer medications in the home until the staff member successfully completes the Department-approved medication administration course.
- The administrator will review all staff person training records to ensure all staff persons administering medications are qualified to administer medications and the documentation is present by 12/12/25.
- Beginning 12/12/25, the administrator will review all medication administration training records quarterly to ensure all staff persons continue to meet the qualifications to administer medications.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

191 - Resident Right to Refuse

34. Requirements

2600.

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

Description of Violation

Resident #1, admitted [REDACTED]/25, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The administrator or designated staff person will educate Resident #1 on their right to question or refuse medication if the resident believes there may be a medication error by 12/12/25.
- The administrator will be educated on educating residents on the right to question of refuse medication if the resident believes there may be a medication error and documenting the education by 12/12/25.
- The administrator will review all current resident records to ensure all residents have been educated on the right to question of refuse medication if the resident believes there may be a medication error and the proper documentation is in the resident's record by 12/12/25.
- By 12/12/25, the administrator will add the residents right to the resident-home contract. Newly admitted residents, beginning 12/12/25, will review the updated contract to ensure the residents have been educated on their right to question or refuse medication if the resident believes there may be a medication error.
- Documentation of education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

225a - Assessment 15 Days

35. Requirements

2600.

225a - Assessment 15 Days (continued)

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

An assessment was not completed for Residents #1, #10, and #2, who were admitted to the home on [redacted] 25, [redacted] /25, and [redacted] /25 respectively.

Repeated Violation- 12/17/24, 7/9/24, et al.

Plan of Correction

Directed [redacted] 11/12/2025)

- A written initial assessment will be completed for Residents #1, #10 and #2 by 12/12/25 by the administrator.
- The administrator and all staff persons completing assessments will be educated on regulation 2600.225(a) by 12/12/25.
- By 12/12/25, the administrator or designated staff person will review all current resident assessments to ensure completion and accuracy.
- Beginning 12/12/25, the administrator will review the record of a newly admitted resident within 15 days of moving into the home to ensure an assessment has been completed timely.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

225c - Additional Assessment

36. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #4's assessment, dated [redacted] /24, indicated the resident can self-administer medication with assistance at offering medication at the prescribed times. However, Staff Member D, the [redacted], indicated Resident #4 is not capable of self-administering medications and requires staff to complete all steps of medication administration for the resident. Resident #4's assessment has not been updated to reflect this change in the resident's need for assistance during medication administration.

Resident #4's assessment, dated [redacted] /24, did not include the following diagnoses as indicated on the resident's most recent medical evaluation, completed on 1/30/25: Acquired Arteriovenous Malformation, Coronary Artery Disease, Coronary Arteriosclerosis, Deep Vein Thrombosis, History of Alcohol Abuse, History of Cardiac Arrest, Panacinar Emphysema, Peripheral Artery Disease, and Stage 3 Chronic Kidney Disease.

Plan of Correction

Directed ([redacted] - 11/12/2025)

- Resident #4 will be reassessed in the area of self-administration of medication and the resident's assessment will be updated to reflect the changes in areas of medication administration and medical diagnoses and needs by 12/12/25.
- The administrator and any staff responsible for the completion of resident assessments will receive

225c - Additional Assessment (continued)

education on regulation 2600.225(c) by 12/12/25.

- The administrator will complete an initial audit of all resident assessments to ensure each assessment reflects the resident's current needs by 12/12/25.
- Beginning 12/12/25, the administrator will complete quarterly audits of 25% of the current census resident assessments to ensure their any changes have been updated accurately.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

227a - Support Plan 30 Days**37. Requirements**

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted on [REDACTED] 25, Resident #10 was admitted on [REDACTED] 5, and Resident #2 was admitted on [REDACTED] /25; however, the residents' initial support plans were not completed.

Repeated Violation - 7/9/24, et al.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- A support plan will be completed for Residents #1 and #10 by 12/12/25 by the administrator.
- The administrator and all staff persons completing support plans will be educated on regulation 2600.227(a) by 12/12/25.
- By 12/12/25, the administrator or designated staff person will review all current resident support plans to ensure completion and accuracy.
- Beginning 12/12/25, the administrator will review the record of a newly admitted resident within 25 days of moving into the home to ensure a support plan has been completed timely.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

227e - Self Administer Medication**38. Requirements**

2600.

227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident #7's assessment and support plan, dated [REDACTED] /24

227e - Self Administer Medication (continued)

, does not document the resident's ability to self-administer medications. Resident #7's assessment indicated "resident cannot self-administer medications". However, the resident's description of medication needs indicated the resident is capable of self-medicating some medications as such creams and insulin and the plan to meet the resident's medication needs indicated trained staff will administer the resident's medication daily. Per Staff Member D, Resident #7 self-administers medications including [REDACTED] insulin.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The administrator will consult with Resident #7's physician to identify the specific medications the resident can self-administer by 12/12/25. The administrator will file the physician's order for self-administering medications and the specific medications in the resident's record.
- The administrator will update Resident #7's assessment and support plan to properly reflect the areas of need and support provided by the home by 12/12/25.
- The administrator will review all current resident medical evaluations and support plans to ensure they properly document the ability of the resident to self-administer medications or the need for medication reminders or medication administration by 12/12/25.
- Beginning 12/12/25, the administrator will complete quarterly audits on 25% of the current census resident assessment and support plans to ensure the resident's current ability to self-administer medications and supports provided are current and accurate.
- Documentation of completed education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025

251b - Record Entries Legible

39. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on Resident #10's medical evaluation, dated [REDACTED]/25, altering the type of Td/Tdap immunization the resident received on 7/11/25.

Plan of Correction

Directed [REDACTED] - 11/12/2025)

- The administrator and all staff in the home will receive education on regulation 2600.251(b) by 12/12/25.
- The administrator will develop a policy on resident records to include a process to draw a line through errors or changes such that the original entry is still legible, and the change includes the staff name/initials and date of the change. All staff will receive education on the policy by 12/12/25.
- Beginning 12/12/25, the administrator will complete monthly audits on resident records to ensure correction fluid has not been used and that the resident's record is permanent, legible, dated and signed by the staff person making the entry.
- Documentation of education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 12/12/2025