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

November 3, 2025

[redacted]
EC OPCO READING LLC
[redacted]
ECLIPSE SR LIV ATTN LICENSING
[redacted]

RE: CELEBRATION VILLA OF EXETER
9 COLIN COURT
READING, PA, 19606
LICENSE/COC#: 22716

[redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/16/2025, 07/18/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CELEBRATION VILLA OF EXETER* **License #**: *22716* **License Expiration**: *07/11/2026*

Address: *9 COLIN COURT, READING, PA 19606*

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

Administrator

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

Legal Entity

Name: *EC OPCO READING LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/17/2017* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *73* **Waking Staff**: *55*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/18/2025*

Inspection Dates and Department Representative

07/16/2025 - On-Site: [redacted]

07/18/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* **Residents Served**: *51*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *25* **Residents Served**: *21*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *51*

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

Have Mobility Need: *22* **Have Physical Disability**: *1*

Inspections / Reviews

07/16/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/07/2025*

08/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/06/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/25/2025*

Inspections / Reviews *(continued)*

09/11/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/25/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *09/05/2025*

11/03/2025 Document Submission

Submitted By [redacted] **Date Submitted:** *10/31/2025*

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

Description of Violation

On [redacted] at 10:15 a.m., 12:00 p.m., and 3:00 p.m., an agent of the Department, requested access to medication administration training, it was received by the agent of the Department at approximately 3:30 p.m.

Plan of Correction ***Accept [redacted] - 08/18/2025)***

Action: During the inspection on 7/16/25, the Executive Director, Director of Nursing, and Memory Care Coordinator gathered the requested records. The Director of Nursing misunderstood the request for the specific medication administration training records resulting in the delay in providing the requested information. The records were provided to the agent of the Department as soon as the misunderstanding was resolved.
Training: On 7/17/25 the Executive Director and Director of Nursing were trained by the Regional Director of Operations on Regulation 2600.5.a. Training records will be kept in accordance with Regulation 2600.65i.
Ongoing: This area will be discussed and monitored by the leadership team at the monthly Quality Assurance meetings starting on 8/6/25. During future inspections the Director of Nursing will ask the agent of the Department for a recap of what is requested at the beginning of the inspection to ensure understanding and that there is no delay in providing records to the agent of the Department. Documentation of the Quality Assurance meeting will be kept.

As for Violation 5A1, I fully acknowledge that, as this was my first inspection, I wasn't as organized as I should have been. While there was a bit of a wait, I believe it wasn't excessive—especially compared to what we saw during the height of the COVID pandemic. Everything was handled the same day, and I sincerely hope this can be viewed as a learning experience rather than something warranting a formal violation.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], Resident [redacted] passed away. The home did not report this incident to the department until [redacted].

On [redacted],Resident [redacted] activated a smoke detector, causing an evacuation event. The home did not report this incident to the Department until [redacted].

Plan of Correction ***Accept [redacted] 08/18/2025)***

Action: Resident [redacted] passed away on [redacted] The incident report was sent to the Department by Memory Care

16c Written Incident Report (continued)

Coordinator on 4/3/25 via email with confirmation attached. Resident [redacted] activated the smoke detector on 5/10/25, which caused an evacuation event. The incident report was sent to the department on 5/12/25 by former Executive Director via email with confirmation attached. The Memory Care Coordinator and new Executive Director were informed that two incident reports were not completed within the proper timeframe. The Memory Care Coordinator acknowledged that the incident report was submitted late, and the Executive Director scheduled training for 7/17/25 on timelines for reportable incidents.

Training: On 7/17/25 the Regional Director of Operations trained the Executive Director, Director of Nursing, and the Memory Care Coordinator on Regulation 2600.16c. In accordance with Regulation 2600.65i training records will be kept.

Ongoing: Incident reports will be sent to the Department within 24 hours of the event by the Executive Director, Director of Nursing or Memory Care Coordinator to ensure compliance with this regulation. They will hold each other accountable to the timeline that the written incident must be sent according to Regulation 2600.16c. The required reportable Incidents will be reviewed and monitored by the leadership team at the monthly Quality Assurance Meetings starting on 8/6/2025. Documentation of the Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)

17 - Record Confidentiality

3. 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 [redacted] at approximately 9:40 a.m., the computer on the medication cart was unlocked, unattended, and accessible allowing access to resident medical records.

On [redacted] at approximately 1:30 p.m. there were two white binders (Resident Resources and POC Reports) with resident's information on top of the medication cart in the personal care unit, unlocked, unattended and accessible allowing access to resident personal information.

Plan of Correction ***Accept ([redacted] - 08/18/2025)***

Action: On 7/16/25 with the agent of the Department present, the Executive Director immediately closed the computer, picked up the binders and placed them in the locked nursing office. The Executive Director also addressed the employee, immediately on 7/16/25, about the need to lock or close the computer when the medication cart is unattended to keep confidentiality of medical records.

Training: On 7/17/25 the Executive Director trained all managers on Regulation 2600.17 to ensure record confidentiality. From 7/17/25 through 8/5/25, the Director of Nursing and the Memory Care Coordinator will train Medication Technicians and Direct Care Staff on Regulation 2600.17 to ensure record confidentiality. Training records will be kept in accordance with Regulation 2600.65i.

Ongoing: Starting on 7/17/25 the Executive Director, Director of Nursing, and Memory Care Coordinator will observe that the computer and all confidential records on the medication carts are stored in secure location to ensure

17 - Record Confidentiality (continued)

record confidentiality is maintained. The observations will continue being done daily starting 7/18/25 by the Director of Nursing and /or the Memory are Coordinator and/or the Executive Director and/or the Manager on Duty when walking through the community. This will be done daily for 4 weeks, then weekly for 3 weeks, then monthly. Documentation of findings will be kept. This area will be discussed and monitored by the leadership team at monthly Quality Assurance meetings starting on 8/6/25. Documentation of the Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)

51 - Criminal Background Check

4. Requirements

2600.

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

Description of Violation

Staff person A hired [redacted], and has not lived in Pennsylvania within the past 2 years. An FBI fingerprint background check was not completed.

Staff person B hired [redacted], and has not lived in Pennsylvania within the past 2 years. An FBI fingerprint background check was not completed.

Plan of Correction ***Accept [redacted] 08/18/2025)***

Action: On 7/16/25 during the inspection, the Executive Director provided a PA criminal background check for staff persons A and B. On 7/17/25, staff person A was made aware of needing an FBI fingerprint done for the criminal background check to be done. Staff person A is no longer employed by the Home as of 7/18/25. Staff person B completed an FBI background check on 2/21/25 and started employment on 4/10/25. On 7/31/25, staff person B was notified of the need for FBI background check and on 7/31/25 staff person B provided a copy of the FBI criminal background check to the Executive Director, placed it in the employee file.
Training: On 7/17/25, the Executive Director trained all managers on regulation 2600.51 to ensure that FBI background check is completed if potential employee is not living in PA for the past 2 years. Training record documentation will be done in accordance with regulation 2600.51.
Ongoing: The Executive Director will monitor compliance with the Administrative Assistant on regulation 2600.51 of the need to ensure FBI background check is complete if a potential employee has not lived in PA for the past 2 years. The Executive Director and/or Administrative Assistant will use the employee checklist and add a section for amount of time living in PA to improve monitoring for all potential employees. Regulation 2600.51 will be discussed at Quality Assurance meetings starting 8/6/25. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)

62 - Contact List

5. Requirements

62 Contact List *(continued)*

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 person C, D, and E, are listed on the current staff list that was proved to the Department at 10:45 a.m. During the exit conference, the administrator, Director of Nursing, and Memory Care Coordinator all indicated the three staff members have not been employed at the facility for over 2 years.

Plan of Correction ***Accept [redacted] - 08/18/2025)***

Action: On 7/16/25 during the exit conference the agent for the Department was discussing employee records and that is when it was determined that the Administrative Assistant provided the agent of the Department with an outdated staff contact list. The Executive Director immediately provided a current staff contact list.
Training: On 7/17/2025 the Executive Director trained managers and the Administrative Assistant on Regulation 2600.62 to ensure there is always a current staff contact list. Training records will be kept in accordance with Regulation 2600.65i.
Ongoing: Starting on 7/17/2025 the Administrative Assistant will keep the staff contact list current by updating the list as employees terminate employment or when new employees are hired. The Executive Director will monitor compliance by reviewing the contact list weekly to ensure that the Administrative Assistant is keeping a current contact list. Documentation of findings will be kept.
The findings and the contact list will be reviewed with the leadership team at the monthly Quality Assurance meetings starting on 8/6/2025. Documentation of the Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)

82c Locking Poisonous Materials

8. 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

Hand Sanitizer, with a manufacture's label indicating "if swallowed, get medical help," was unlocked, unattended, and accessible to residents in the Memory Care Unit Kitchenette. Not all the residents of the home, including the Memory Care Unit Residents, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 08/18/2025)***

Action: On 7/16/2025, during the walk through of the building the State Representative found hand sanitizer on the Secured Memory Care Kitchenette which is surrounded by the Unit desk. The Executive Director in training, immediately removed hazardous material and placed it was place in a locked drawer.
Training: On 7/17/2025, the Executive Director trained all managers on regulation 2600.82c. regarding poisonous materials needing to be kept locked and inaccessible to residents in the Secured Dementia Care Unit. Director of Nursing, Memory Care Coordinator and Dining Director trained all staff on regulation 2600.82c. Training was initiated on 7/17/25 and completed on 8/5/2025. Training record documentation will be kept in accordance with regulation 2600.65i.
Ongoing: On 7/17/2025 the Executive Director, Director of Nursing, and Memory Care Coordinator began to monitor that hazardous materials are kept secured. The observations will be done daily starting 7/18/2025 by the Director

82c - Locking Poisonous Materials (continued)

of Nursing and /or the Memory care Coordinator and/or the Executive Director and/or the Manager on Duty when walking through the home. Documentation of the observations will be kept. This area will be discussed and monitored by the leadership team at monthly Quality Assurance meetings starting on 8/6/2025. Documentation of the Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)

85e - Trash Outside Home

9. 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

Cardboard, empty trash bags, wood pallets and furniture were noted outside of the dumpster behind the facility.

Plan of Correction ***Accept [redacted] - 08/18/2025)***

Action: During the Department's inspection on 7/16/2025 it was noted that there was cardboard, empty trash, wood pallets, and furniture outside of the dumpster of the home. On 7/16/225 the Dining Director and Dining Staff removed all items and placed them in the dumpster before the exit conference.
Training: On 7/17/2025, the Executive Director trained all managers on regulation 2600.85e. Director of Nursing, Memory Care Coordinator and Dining Director trained all staff on regulation 2600.82e. Training was initiated on 7/17/25 and completed on 8/5/2025. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: On 7/17/2025 the Executive Director, Director of Nursing, Dining Director, Memory Care Coordinator and the Manager on Duty started monitoring the dumpster area daily to ensure that no trash is outside the dumpster. Documentation of findings will be kept. This area will be discussed and monitored by the leadership team at monthly Quality Assurance meetings starting 8/6/2025. Documentation of the Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] 09/12/2025)

86b - Bathroom

10. Requirements

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

Description of Violation

The bathroom in room [redacted] does not have an operable window or ventilation fan. The bathroom fan is inoperable and there is no ventilation in the bathroom.

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

Action: On 7/16/2025, during walk through of the home with state representative it was found that ventilation fan in bathroom of 315 was not working properly. The Regional Maintenance Director was notified by the Executive Director on 7/16/2025 of the need to have the vent repaired. The original manufacturer no longer manufactures the fan and on 7/31/25, the Regional Maintenance Director was able to find a comparable motor and the Executive Director ordered a replacement fan on 7/31/2025 from CSH electric motor supply. The new fan was shipped on

86b - Bathroom (continued)

8/5/25 and is to be delivered on 8/7/25. The Regional Maintenance Director will replace the bathroom vent upon delivery. The Department will be notified when the ventilation fan has been repaired and operable. An audit of the function of all bathroom ventilation fans was initiated on 8/4/25 and was completed on 8/6/25.
Training: On 7/17/25 the Executive Director trained all managers on regulation 2600.86b to ensure all bathroom exhaust fans for ventilation are operable. The Director of Nursing, Memory Care Coordinator and Dining Director educated all staff on regulation 2600.86b to ensure all exhaust fans for ventilation are operable which started on 7/17/25 and completed on 8/5/2025. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: The management team will instruct staff to report any ventilation fan that is not properly working to a manager. All managers will input a work order to let the Maintenance Director know when a ventilation fan is not properly working and the Maintenance Director will address. Regulation 2600.86b will be discussed and monitored by the leadership team at monthly Quality Assurance meetings starting 8/6/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/17/2025)

89a - Water Pressure

11. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On [redacted] at 1:15 p.m., there was no water coming out of the bathroom sink in room [redacted] when the faucet was turned on.

Plan of Correction ***Accept [redacted] - 08/18/2025)***

Action: On 7/16/2025, during the walk through with the state representative it was found that there was no hot water in room [redacted] in the sink. The Regional Maintenance Director was notified by the Executive Director on 7/16/2025 to have the water pressure for cold and hot water repaired to be in compliance with regulation 2600.89a and meet the needs of the resident in room [redacted] The Regional Maintenance Director fixed the water faucet water pressure in room [redacted] on 7/17/25.
Training: On 7/17/25 the Executive Director trained all managers on regulation 2600.89a to ensure water pressure in all faucets in the home has cold and hot water. The Director of Nursing, Memory Care Coordinator and Dining Director educated all staff on regulation 2600.89a to ensure all water faucet water pressure is operable and to comply with regulation 2600.89a. The training started on 7/17/25 and was completed on 8/5/2025. Training record documentation will be kept in accordance with regulation 2600.65i. The Maintenance Director will check water pressure monthly in the resident bathrooms and will report back at Quality Assurance meetings. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: The management staff will continue to instruct staff to report when the water pressure is not properly working to the manager. All managers will notify the Maintenace Director by completing a work order to ensure there is cold and hot water coming out of all faucets. Regulation 2600.89a and audit findings will be monitored by the Maintenance Director monthly starting on 8/6/25 and documentation will be kept. This area will be discussed by the leadership team at monthly Quality Assurance meetings starting 8/6/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

89a Water Pressure *(continued)*

Implemented [redacted] - 09/12/2025)

95 Furniture and Equipment

12. Requirements

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

Description of Violation

On [redacted] at approximately 9:50 a.m. the light fixture on the porch outside the exit of the Secure Dementia Care Unit was hanging down approximately 2 inches from the facia.

Plan of Correction ***Accept [redacted] 08/18/2025)***

Action: On 7/16/2025 during the State Representative's walk through of the home it was found that there was a light outside the door in the Secured Dementia Care Unit that was hanging down and not securely attached. On 7/16/2025 the Executive Director notified the Regional Maintenance Director of the need for the light fixture to be fixed. The Regional Maintenance Director secured the light fixture on 7/18/2025. An audit of the function and good repair of all outdoor light fixtures was initiated on 8/4/25 and was completed on 8/6/25.
Training: The Executive Director trained all managers on regulation 2600.95 on 7/17/2025. The Executive Director, Director of Nursing, Memory Care Coordinator and Dining Director trained all staff to report any fixtures or equipment that is not secured. Training started on 7/17/25 and was completed on 8/5/2025. Training record documentation will be kept in accordance with regulation 2600.65i.
Ongoing: The management staff will continue to instruct staff to report any light fixtures that are not secure to the manager. All managers will complete a work order for any light fixtures found that are not secured and the Maintenance Director will secure. This area will be discussed and monitored at monthly Quality Assurance meetings starting 8/6/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)

101j7 Lighting/Operable Lamp

13. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

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

Plan of Correction ***Accept [redacted] 08/18/2025)***

Action: On 7/16/25, during the walk-through with the state representative it was found that room [redacted] did not have a light source at the bedside. On 7/16/2025 the Executive Director immediately provided a bedside lamp. Between 8/4/25 through 8/6/25 the Housekeeper checked each resident room to ensure there is a source of light at the bedside. Findings of room checks will be kept.
Training: The Executive Director trained all managers on 7/17/2025 on regulation 2600.101j7 to ensure all residents have light source at bedside. The Director of Nursing, Memory Care Director, and Dining Director trained all staff on regulation 2600.101j7 which started on 7/17/2025 and ended 8/5/2025 to ensure all residents have a light source at bedside that can be turned on/off. Training records will be kept in accordance with regulation 2600.65i.

101j7 Lighting/Operable Lamp (continued)

Ongoing: The Executive Director, Director of Nursing, Memory Care Coordinator and or the Dining Director will continue to instruct staff to report any residents without a light source at their bedside to the manager. All managers will complete a work order for the Maintenance Director to address. The Maintenace Director will check monthly that residents have an operable lamp or other light source at their bedside. The Maintenace Director will monitor this area to ensure compliance with regulation 2600.101j7. Documentation will be kept. The findings of this area will be discussed at the monthly Quality Assurance meetings beginning 8/6/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 11/03/2025)

103f - Refrigerator/Freezer Temps

14. 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

There was no thermometer in the small freezer in the kitchenette in the Secured Dementia Care Unit.

Repeat violation: [redacted]

Plan of Correction ***Accept [redacted] - 08/18/2025)***

Action: During the walk through on 7/16/25, it was found on the Secured Dementia Care Unit that the small freezer in the kitchenette on the Secured Dementia Care Unit did not have a thermometer in the freezer. On 7/16/25 the food was removed from the freezer. On 7/18/25 the thermometer was placed in the freezer to ensure compliance with regulation 2600.1013f. The findings of the audit will be documented, and the freezers will have thermometers.
Training: The Executive Director trained all managers on 7/17/2025 on regulation 2600.103f to ensure all freezers have thermometers and are monitored daily. The Director of Nursing, Memory Care Coordinator and Dining Director trained all staff on regulation 2600.103f that started on 7/17/2025 and ended 8/5/2025 to ensure freezers have thermometers and are monitored daily and documented. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: On 7/17/2025 the Executive Director, Director of Nursing, Dining Director and Memory Care Coordinator will monitor for thermometer in the freezer. The ongoing monitoring of staff recording will continue being done daily starting 7/18/2025 by the Director of Nursing and /or the Memory are Coordinator and/or the Executive Director and/or the Manager on Duty when walking through the home. This will be done daily for 4 weeks, then weekly for 3 weeks, then monthly. Documentation of findings will be kept. This area will be discussed and monitored by the leadership team at monthly Quality Assurance meetings starting on 8/6/2025. Documentation of the Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)

124 - Notice to Fire Department

15. Requirements

2600.

124 - Notice to Fire Department *(continued)*

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

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction ***Accept [redacted] - 08/18/2025)***

Action: On 7/16/2025 during the inspection attached letter was provided but was deemed unacceptable. New letter composed and sent to Fire Department by Executive Director on 8/1/2025.
Training: The Regional Director of Operations trained the Executive Director on 7/17/2025 on regulation 2600.124 to ensure notice to fire department is done. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: Executive Director to send letter yearly or as needed due to changes in the home. The Executive Director will ensure compliance with regulation 2600.124. This area will be discussed and monitored by the leadership team at monthly Quality Assurance meetings starting on 8/6/2025. Documentation of the Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] 09/12/2025)

132c - Fire Drill Records

16. Requirements

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

Description of Violation

The fire drill record for the drill conducted on [redacted] at 11:36, [redacted] at 4:05, and [redacted] at 5:33 does indicate if the drill was conducted in the a.m. or p.m.

The fire drill record for the drill conducted on [redacted] does not include time, number of residents in the home, number of residents evacuated.

Plan of Correction ***Accept [redacted] 08/18/2025)***

Action: On 7/16/25 during the review of fire drill records it was noted that am/pm was not used on fire drill record completed by the Maintenance Director. On 7/16/25 the Executive Director immediately notified the Regional Maintenance Director of this finding.
Training: The Regional Director of Operations trained the Executive Director on 7/17/25 on regulation 2600.132c to ensure am/pm is included on the fire drill record. The Executive Director will train the Maintenance Director when the position is filled. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: The Executive Director or Maintenance Director will conduct a monthly fire drill and will include am/pm on the fire drill record starting with the fire drill scheduled to be done on 7/17/25. The fire drill records will be kept for compliance with regulation 2600.132c. The Executive Director or Maintenance Director will ensure the fire drill record is completed according to this regulation immediately following the fire drill before the fire drill record is filed. The fire drill records will be monitored and reviewed by the leadership team at the monthly Quality Assurance

132c - Fire Drill Records (continued)

meetings starting 8/6/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)

132h - Designated Meeting Place

17. Requirements

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

Description of Violation

During the fire drill on [redacted] at 11:36, 1 resident did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Accept [redacted] 08/18/2025)***

Action: On 7/16/25 during the review of fire drill records it was found that one resident was not evacuated during a fire drill on 9/30/24 to the designated meeting place within the fire-safe area. The documentation shows there were 55 residents in the building and 54 were evacuated without additional information. The Regional Maintenance Director performed a fire drill on 7/17/25. At that time all residents were evacuated, and documentation was accurate on the fire drill record. The Executive Director ensured documentation was correct on the fire drill record on 7/17/25 before filing the fire drill record.
Training: The Regional Director of Operations trained the Executive Director on regulation 2600.132h, on 7/17/25 to ensure all residents are evacuated and that the fire drill record is accurate. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: The Executive Director or Maintenance Director will perform a monthly fire drill to include evacuation of all residents to a designated meeting place away from the building or within the fire safe area which will be documented on fire drill record starting 7/17/25. The Executive Director and/or the Maintenance Director will audit fire drill records monthly with documentation kept starting 7/17/25. The findings will be reviewed by the leadership team during monthly Quality Assurance meetings starting 8/6/2025. Documentation of Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)

183d - Prescription Current

18. 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 [redacted] prescribed for Resident [redacted] was in the home's medication cart. The medication was discontinued prior to [redacted]

Plan of Correction ***Accept [redacted] 08/18/2025)***

Action: On 7/16/25 during the medication audit, a medication was found that was no longer prescribed to resident [redacted] On 07/17/25 the Memory Care Coordinator removed Resident [redacted] Benzonanate medication from the cart. Cart Audits were completed on 7/23/25 and no other discontinued medications were found on the cart. Documentation

183d - Prescription Current (continued)

of the cart audit will be kept.
Training: On 7/17/25, the Executive Director trained Memory Care Coordinator and Director of Nursing in regulation 183d to ensure all medications that no longer have an active prescription are removed from the cart. The Director of Nursing, Memory Care Coordinator trained all medication technicians on regulation 183d and reviewed the appropriate way to complete a cart audit. The training started on 7/17/25 and ended 8/5/25 to ensure all medications without an active prescription are removed from cart. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: The Executive Director, Director of Nursing or Memory Care Coordinator will monitor that medication audits are occurring correctly starting 7/18/25. Weekly medication cart audits will be done by a Medication Technician starting 7/18/25. The Executive Director, Director of Nursing or Memory Care Coordinator will audit the medication monthly starting 8/1/25 with documentation kept. Medication cart audits will be reviewed at monthly Quality Assurance meetings by the leadership team starting 8/6/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)

233c - Key-Locking Devices

20. Requirements

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

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the gate to exit the Secure Dementia Care Unit.

Repeat Violation [redacted]

Plan of Correction ***Accept [redacted] - 08/18/2025)***

Action: On 7/16/25 during the inspection walk through it was noted by the state representative that the directions to unlock the exit gate were not conspicuously posted to exit the Secured Memory Care Unit. On 7/16/25 the Memory Care Coordinator conspicuously posted the home's locking mechanism directions near the gate to exit the Secured Dementia Care Unit.
Training: The Executive Director trained all managers on regulation 2600.233c on 7/17/2025. The Executive Director, Director of Nursing, Memory Care Coordinator and Dining Director trained all staff to know that the unlocking mechanism directions need to be on both sides of the gate. Training started on 7/17/25 and was completed on 8/5/2025. Training records will be kept in accordance with regulation 2600.65i.
Ongoing: Sarting 7/18/2025 the Director of Nursing and /or the Memory are Coordinator and/or the Executive Director and/or the Manager on Duty will monitor that the unlocking mechanism directions is conspicuously posted near the gate when walking through the home and to ensure the signage did not fall off the gate. Starting 7/17/25 this will be done daily for 4 weeks, then weekly for 3 weeks, then monthly. Documentation of findings will be kept. This area will be discussed and monitored by the leadership team at monthly Quality Assurance meetings starting on 8/6/2025. Documentation of the Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *09/03/2025*

Implemented [redacted] - 09/12/2025)