

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

December 3, 2025

[REDACTED], ADMINISTRATOR
ALWAYS ON CARE LLC
[REDACTED]

RE: ALWAYS ON CARE
600 NORTH LAUREL STREET
HAZELTON, PA, 18201
LICENSE/COC#: 23006

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/16/2025, 07/17/2025 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: ALWAYS ON CARE License #: 23006 License Expiration: 08/18/2025
 Address: 600 NORTH LAUREL STREET, HAZELTON, PA 18201
 County: LUZERNE Region: NORTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: ALWAYS ON CARE LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 Date: 04/22/2010 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 22 Waking Staff: 17

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Complaint Exit Conference Date: 07/17/2025

Inspection Dates and Department Representative

07/16/2025 - On-Site: [REDACTED]
 07/17/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 26 Residents Served: 22
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 0
 Number of Residents Who:
 Receive Supplemental Security Income: 13 Are 60 Years of Age or Older: 19
 Diagnosed with Mental Illness: 18 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 0 Have Physical Disability: 1

Inspections / Reviews

07/16/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/21/2025

08/26/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 09/30/2025
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 09/03/2025

Inspections / Reviews (*continued*)

09/15/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/30/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 09/30/2025

12/03/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/30/2025

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 7/16/25, at 9:10a.m., Department Representatives, requested a staff and resident list from Staff person A. At 10:15 a.m., Department Representatives went to the office of Staff person A and were provided a staff list and resident list. Representatives then requested resident records that were not provided until 12:30 p.m.

Repeat Violation: 11/27/24, et al.

Plan of Correction

Directed ([REDACTED] - 09/15/2025)

After the inspectors left the home, the room of Resident #6 was checked, and it was concluded that the lamp was merely unplugged by the resident. The resident unplugged the lamp and input their charger for their phone. To ensure compliance with 101j7, the Administrator will ensure the importance of having an operable lamp in their rooms. Immediate action has been taken to address Resident #6's lamp by plugging in the lamp, testing it to confirm operability. On 7/25/25 all other resident lamps were checked and confirmed operable. By 9/30/25, residents will be educated to not unplug their lamps, and staff educated way to provide residents with necessary outlets for their electronic needs in their rooms, if needed.

Proposed Overall Completion Date: 09/30/2025

Directed: The administrator or designee will provide training to all staff members to provide immediate access of records to the department upon request. Staff will provide records to the department immediately upon request.

Directed Completion Date: 09/22/2025

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

17 - Record Confidentiality

2. 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 7/16/25 at 9:30 a.m., the license inspection summary from 7/9/24 and 11/27/24 were posted across from the elevator on the first floor and included the privacy code page with the names of 4 residents.

17 - Record Confidentiality (continued)

Plan of Correction

Accept (█ - 09/09/2025)

The administrator will ensure that resident records remain confidential and are not publicly displayed or accessible to anyone without proper authorization, except as permitted by law. On 7/19 the home removed the privacy code page listing resident names from public posting. After every inspection, the Administrator and Administrator Designee will review the posted violation report to ensure the Privacy Coding is not added to the documents. The administrator or designee will review posted LIS's for confidential information at least monthly until 11/30/25.

Proposed Overall Completion Date: 11/30/2025

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented (█ - 12/03/2025)

25a - Written Contract and Review

3. 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 to the home on █, did not have a resident-home contract completed with the current legal entity. The only contract was completed on █ with the previous legal entity.

Plan of Correction

Accept (█ - 09/15/2025)

At the time the representatives came to the facility, the administrator was physically in the process of revamping our filing system. We do have a signed contract in our records, which we placed in █ file.

The date that the contract was added to the resident file was 7/20/25.

The administrator designee will monitor it's compliance to assure, contracts are in every binder through an audit by 9/30/25.

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented (█ - 10/28/2025)

57d - Waking Hours

4. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 6/29/25, 6/30/25, and 7/1/25 the home had 21 residents in-house requiring 15.75 direct care hours to be provided during waking hours. On 6/29/25 & 7/1/25 only 13.75 of the required hours were provided during waking hours and on 6/30/25, only 12 hours were provided during waking hours.

57d - Waking Hours (continued)

Plan of Correction

Directed (█) - 09/15/2025

On 6/29/25, 6/30/25, and 7/1/25, the administrator was available as well as another trained staff member. However, it was not emphatically documented as such. The administrator will ensure the documentation indicates that at least 75% of the personal care service hours specified in 2600.57(b) and (c) are provided during waking hours, as defined by policy. The Administrator or designee will align daily schedules to ensure daytime coverage and will have the staff schedule clearly indicate waking-hours assignments for every shift by 9/15/25. The administrator is responsible for ensuring the documentation indicates that at least 75% of the personal care service hours specified in 2600.57(b) and (c) are provided during waking hours, as defined by policy. The administrator will monitor its ongoing compliance until 10/30/25.

Proposed Overall Completion Date: 09/30/2025

Directed: In addition to the above plan of correction, the administrator or designee will review the schedule 1 week in advance and ensure required daytime hours are being met. These checks will be documented with the week checked, person completing the check, and date of the check. If any issues are identified, staff will be added to meet the requirements.

Directed Completion Date: 09/30/2025

Implemented (█) - 12/03/2025

58a - Awake Staff 16 or More

5. Requirements

2600.

58.a. If a home serves 16 or more residents, all direct care staff persons on duty in the home shall be awake at all times one or more residents are present in the home.

Description of Violation

On 7/15/25, 22 residents were present in the home. Staff B was on duty from 6:30a.m. 7/15/25 to 6:30a.m. on 7/16/25. Staff B indicated that they slept from 11:00p.m. to 6:00a.m. Staff B stated that the residents would wake them if they needed something.

Plan of Correction

Directed (█) - 09/15/2025

To address the 60.a Staff/Support Plan requirement, the Administrator will ensure that all direct care staff on duty in a home serving 16 or more residents are awake whenever residents are present. Immediate actions include enforcing a no-sleep-on-duty policy for direct care areas and requiring staff to remain awake or be in an approved break area if on breaks, with a second awake staff member assigned whenever residents are present. The administrator will train all direct care staff on awake coverage expectations, with training completed by 09/15/2025. The administrator will monitor it's compliance, and create a written policy that explicitly defines what constitutes sleeping on the job and outlines the progressive disciplinary actions, such as a verbal warning for a first offense, followed by a written warning, and potential termination for repeated offenses by 9/15/25.

Proposed Overall Completion Date: 09/15/2025

Directed: In addition to the above plan of correction, the administrator or designee will do weekly checks

58a - Awake Staff 16 or More (continued)

for 4 weeks, to verify staff is awake between 11p.m. and 7a.m. These checks will be documented with date, person completing check, and staff observed. Any issues will be immediately addressed and documented.

Directed Completion Date: 09/30/2025

Implemented (█) - 10/28/2025)

85a - Sanitary Conditions**7. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 7/16/25 at 10:45 a.m., the refrigerator section of the refrigerator/freezer #5 in the basement of the home was covered with orange sticky substances, brown and black particles, and white hairy substance on the lower section of the refrigerator.

Resident bedroom #8 was covered with greater than 20+ empty beverage cans spread throughout the floor.

The bathmats hanging in the showers in the first and second floor bathroom had a black slimy substance on the bottom of the mat.

Staff person B counted narcotics by pouring the medication on top of the medication cart, removed the glove from their hand, and touched the medication with their bare hand.

Plan of Correction

Directed (█) - 09/15/2025)

The administrator will ensure that sanitary conditions are maintained by immediately addressing all observed deficiencies and instituting ongoing environmental health controls.

Immediate actions include performing a thorough deep clean and sanitization of Refrigerator Freezer #5 in the basement (removing the orange residue, brown/black particles, and any hair or mold-like matter), disposing of the >20 beverage cans spread across Resident Bedroom #8, educating the resident about its proper disposal, and replacing the bathmats in the first and second floor showers by 9/15/25.

The medication counting process will be reviewed and corrected to prevent unsafe practices by educating the med techs again regarding the importance of gloves being worn, and hands washed.

The home will reinforce the cleaning schedule that defines daily, weekly, and periodic cleaning standards, along with policies for infection control and medication handling will be completed by 09/15/2025.

The administrator will monitor its compliance.

Directed: In addition to the above plan of correction, the administrator or designee will complete weekly sanitary checks on all the home's refrigerators and freezers. These checks will be documented with the date, area checked, person making checks, and any issues identified. Any issues identified will be immediately addressed and cleaned. All staff will be educated regarding reporting any sanitary concerns in resident rooms so that these concerns are immediately addressed.

Proposed Overall Completion Date: 09/15/2025

Directed Completion Date: 09/30/2025

Implemented (█) - 12/03/2025)

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 7/16/25, at 11:00a.m. the ceiling in the basement had cracked and falling paint chips. Both of the basement laundry rooms had black substance appearing on the ceiling with a 3-foot radius each. The ceiling in the great room of the basement had a pipe leaking water drops onto the ceiling. The ceiling in visitor room and resident living room had cracked and bubbled paint with an area 2.5 feet in diameter.

Plan of Correction

Directed () - 09/15/2025

The Administrator will ensure that floors, walls, ceilings, windows, doors, and other surfaces are clean, in good repair, and free of hazards as required by 88a. Immediate actions include a thorough deep cleaning and remediation of the basement ceiling where paint is chipping and moisture is present in the laundry room and in the great room in the basement by 9/30/25, cleaning and sanitizing the basement laundry room ceilings where black substance was observed by 9/30/25, and addressing the great room ceiling where a pipe is leaking water by 9/30/25; this will involve securing the areas, repairing the pipe leak, removing and replacing any water-damaged ceiling materials, and implementing interim containment and clean-up procedures by 10/15/25. A professional assessment of any potential moisture-related hazards or mold will be arranged if warranted. In addition, the ceiling in visitor room and resident living room that had cracked and bubbled paint, will be fixed by 10/15/25.

A schedule of checks of the laundry room, great room, and visiting room ceilings will be weekly until 10/30/25 to monitor its compliance by the administrator.

Proposed Overall Completion Date: 09/30/2025

Directed: In addition to the above plan of correction, the issues identified above will all be fixed no later than 9/30/2025.

Directed Completion Date: 09/30/2025

Implemented () - 10/28/2025

101j7 - Lighting/Operable Lamp

9. 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

On 7/16/25 at 12:15 p.m., resident #6's light source at bedside was not operable and would not turn on.

Plan of Correction

Accept () - 09/15/2025

After the inspectors left the home, the room of Resident #6 was checked, and it was concluded that the lamp was merely unplugged by the resident. The resident unplugged the lamp and input their charger for their phone. To ensure compliance with 101j7, the Administrator will ensure the importance of having an operable lamp in their rooms. Immediate action has been taken to address Resident #6's lamp by plugging in the lamp, testing it to

101j7 - Lighting/Operable Lamp (continued)

confirm operability. On 7/25/25 all other resident lamps were checked and confirmed operable.
By 9/30/25, residents will be educated to not unplug their lamps, and staff educated way to provide residents with necessary outlets for their electronic needs in their rooms.

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented (█) - 10/28/2025)

103g - Storing Food**10. Requirements**

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

Description of Violation

On 7/16/25 at 10:20 a.m., an unsealed bag of pizza cheese was stored in the door shelf of the freezer in the main kitchen.

Plan of Correction

Accept (█) - 09/15/2025)

The administrator will ensure that all food is stored only in closed or sealed containers in accordance with 2600.103.g. Immediate action taken on 07/16/2025 included removing the unsealed bag of pizza cheese from the freezer door shelf, repackaging it into a sealed container, labeling with date, and relocating it to proper storage, followed by a rapid audit of nearby items to ensure all foods are sealed and properly stored. Staff will be trained on proper storage, labeling, and containment by 09/15/2025.

The Administrator designee will monitor its compliance with weekly checks until 10/18/25.

Proposed Overall Completion Date: 10/18/2025

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented (█) - 10/28/2025)

121a - Unobstructed Egress**11. 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 7/16/25 at 11:00 a.m., the emergency exit door near the basement laundry room was unable to be opened without use of excessive force.

Repeat Violation: 7/9/24.

Plan of Correction

Directed (█) - 09/15/2025)

The Administrator or designee will ensure that all stairways, hallways, doorways, passageways, and egress routes are unlocked, unobstructed, and operable without excessive force at all times.

Immediate corrective action will include repairing and adjusting the basement laundry-area emergency exit (e.g., panic hardware, latch/strike, hinges, and door closer), lubricating as needed, and testing to confirm the door opens

121a - Unobstructed Egress (continued)

easily from the inside by 9/15/25; if repairs cannot be completed the same day, the door will be taken out of service and a fire watch instituted until corrected. Due to the repeat nature of this violation, the administrator will conduct unannounced spot checks at least twice monthly for 60 days and document in logs until 10/30/25.

Proposed Overall Completion Date: 09/15/2025

Directed: In addition to the above plan of correction, the door will be repaired or replaced by 9/30/2025.

Directed Completion Date: 09/30/2025

Implemented (█) - 10/28/2025)

125a - Combustible Storage**12. Requirements**

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 7/16/25 at 11:00a.m., a portable propane gas tank with a blow torch attachment was stored within 3 feet of the hot water heater in the basement.

Plan of Correction

Accept (█) - 08/26/2025)

The Administrator will ensure that combustible and flammable materials are not located near heat sources or hot water heaters at any time. The portable propane tank with blow torch was removed on 07/16/2025, and the hot water heater/mechanical room was inspected, and cleared.

Due to the nature of this violation, the administrator will conduct unannounced spot checks at least twice monthly for 60 days and document in logs.

Licensee's Proposed Overall Completion Date: 08/21/2025

Implemented (█) - 10/28/2025)

127a - Portable Space Heaters**13. Requirements**

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

On 7/16/25 at 11:00a.m., a portable space heater was on a shelf in the dry food storage in the basement of the home.

Plan of Correction

Directed (█) - 09/15/2025)

The Administrator will ensure that portable space heaters are prohibited anywhere on the premises in accordance with 2600.127a. The heater found in basement dry storage on 07/16/2025 was removed from the building the same day.

The administrator designee will monitor its compliance, by completing checks each week for the next 60 days until 10/30/25.

127a - Portable Space Heaters (continued)

Proposed Overall Completion Date: 10/30/2025

Directed: In addition to the above plan of correction, all staff and residents will be educated regarding prohibition of space heaters in the home.

Directed Completion Date: 09/30/2025

Implemented (█) - 12/03/2025)

132f - Alternate Exit Routes

14. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The front and side doors were the only exit routes used during the fire drills held from 5/31/24 to 6/17/25.

Plan of Correction

Accept (█) - 09/15/2025)

The Administrator will ensure that alternate exit routes are used during all fire drills in accordance with 2600.132f. The next drill will utilize exits other than the front and side doors, and a make-up drill using alternate routes will be completed by 9/30/2025.
The home will ensure every exit is used on a rotating basis across all shifts (no route repeated consecutively), update the Fire Drill log documenting alternate routes. Staff will be retrained on all exit routes, assembly areas, and their roles by 9/30/25.
Compliance will be monitored by the Administrator and designee.

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented (█) - 10/28/2025)

141a 1-10 Medical Evaluation Information

15. 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.

141a 1-10 Medical Evaluation Information (continued)

Description of Violation

Resident #6's medical evaluation dated [REDACTED] was incomplete and did not include any information in section 4.

Repeat Violation: 9/17/24.

Plan of Correction

Accept ([REDACTED] - 09/15/2025)

The administrator will have resident #6's DME updated by the resident's doctor to include missing information in section 4 by 9/30/25. The administrator will ensure that physicians perform all of the required actions during medical evaluations. The actions will be documented on DME form. Attachments will be added to the DME as needed to ensure that all actions are documented by 9/30/25. The administrator will audit all resident DME's for missing required information and update them if needed by 9/30/25.

The administrator will keep and document the audit.

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented ([REDACTED] - 12/03/2025)

185a - Implement Storage Procedures

16. 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 did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff incorrectly transcribing of the blood glucose test results from the individual glucometer. On 7/16/25 at 6:00p.m. the reading on the glucometer of Resident #8 was 174 but was incorrectly transcribed as 173.

Repeat Violation: 10/22/24.

Plan of Correction

Directed ([REDACTED] - 09/15/2025)

The Administrator will continue to ensure that procedures for safe storage, access, security, distribution, use, and documentation of medications and medical equipment are implemented and followed, including accurate transcription to the MAR.

Currently, the MAR is reviewed weekly by the Administrator and a designee. However, this one was missed.

Immediate corrective action included correcting Resident #8's MAR entry using the proper correction protocol, and reviewing the prior 14 days of glucose entries for accuracy.

To prevent recurrence, weekly reviews by two staff members will continue to occur, and staff training will occur by 9/30/25 regarding medication administration, and glucose checks.

The Administrator and designee will monitor its compliance.

Proposed Overall Completion Date: 09/30/2025

Directed: In addition to the above plan of correction, all staff that perform glucose checks will be reeducated on proper documentation on the Medication Administration Record.

185a - Implement Storage Procedures (continued)

Directed Completion Date: 09/30/2025

Implemented (█) - 10/28/2025

187d - Follow Prescriber's Orders

17. Requirements

2600.

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

Description of Violation

Resident #2 is prescribed Isosorbide 30 mg every morning, hold less than 100 systolic and metoprolol 25mg every morning, hold for SBO less than 110 or HT less than 55. The medication was administered without taking the residents blood pressure or pulse, as prescribed on 6/19/25.

Repeat Violation: 7/9/24, 11/27/24 et al.

Plan of Correction

Accept (█) - 09/15/2025

The Administrator will ensure that prescribers' directions are followed at all times, including obtaining and documenting required vital signs prior to administering medications with hold parameters. For Resident #2 and all residents with similar orders, staff will take and record blood pressure and pulse immediately before dosing Isosorbide and Metoprolol and will hold the dose and notify the prescriber per order and policy when parameters are not met.

All medication staff will be re-educated and competency-checked on following prescriber orders and use of the pre-dose checklist by 9/30/25; noncompliance will result in corrective action. The MAC will monitor compliance through daily review of MARs and vital sign logs for 30 days until 9/30/25 and weekly audits for the next 60 days until 10/30/25, with the administrator reviewing results and taking immediate corrective action as needed.

The Administrator and designee will monitor its compliance.

Proposed Overall Completion Date: 10/30/2025

Licensee's Proposed Overall Completion Date: 09/30/2025

Implemented (█) - 12/03/2025

221a - Program Activities

18. Requirements

2600.

221.a. The administrator shall develop a program of activities designed to promote each resident's active involvement with other residents, the resident's family and the community.

Description of Violation

The home does not have a program of activities designed to promote the active involvement of residents with families and the community. Through resident interviews it was confirmed the only activity held is bingo, sporadically.

221a - Program Activities (continued)

Plan of Correction

Accept (█) - 08/26/2025)

The administrator will develop and implement a comprehensive program of activities aimed at promoting each resident's active involvement with other residents, families, and the community, in accordance with 2600.221a. Immediate steps include creating a structured activity calendar that features a variety of group and individual activities beyond bingo, such as arts and crafts, religious meetings, and board game times, family engagement activities. The program will be designed based on resident interests and preferences. Staff will be trained on implementing and documenting resident participation in activities, and residents and families will be encouraged to participate and provide feedback.

Compliance will be monitored through weekly activity participation logs, with continuous adjustment to ensure active engagement. Evidence of progress will include the activity calendar. Target implementation date for the new program is 09/15/2025, with ongoing monitoring and updates scheduled to sustain resident involvement.

Licensee's Proposed Overall Completion Date: 09/15/2025

Implemented (█) - 10/28/2025)

221b - Activity Types

19. Requirements

2600.

221.b. The program must provide social, physical, intellectual and recreational activities in a planned, coordinated and structured manner.

Description of Violation

The home's activities program does not include any gross motor, crafts, sensory, or outdoor activities.

Plan of Correction

Accept (█) - 08/26/2025)

The Administrator will develop and implement a comprehensive program of activities aimed to include gross motor, crafts, sensory, or outdoor activities, in accordance with 2600.221b.

Immediate steps include creating a structured activity calendar that features a variety of group and individual activities that include gross motor, crafts, sensory, or outdoor activities. The program will be designed based on resident interests and preferences. Staff will be trained on implementing and documenting resident participation in activities, and residents and families will be encouraged to participate and provide feedback.

Compliance will be monitored through weekly activity participation logs, with continuous adjustment to ensure active engagement. Evidence of progress will include the activity calendar. Target implementation date for the new program is 09/15/2025, with ongoing monitoring and updates scheduled to sustain resident involvement.

Licensee's Proposed Overall Completion Date: 08/21/2025

Implemented (█) - 10/28/2025)

225c - Additional Assessment

20. 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.

225c - Additional Assessment (continued)

Description of Violation

Resident #7's annual assessment of care needs completed [REDACTED] and Resident #5's annual assessment of care needs completed on [REDACTED] does not address the resident care need for active registry on Meghan's laws while the home is within 100 feet of a school.

Plan of Correction

Directed ([REDACTED]) - 09/15/2025

The administrator will ensure that any resident whose condition significantly changes prior to the scheduled annual assessment receives an additional assessment to document current needs and risks in accordance with 2600.225.c. For Resident #7 and Resident #5, who have existing assessments, by 9/15/25, the home will review their records to identify any significant health or safety changes since their last assessments and will complete comprehensive supplemental evaluations focusing on their active registry status and proximity to schools. Staff will be trained on recognizing signs that warrant an additional assessment, and compliance will be monitored through monthly audits of resident records for the next 60 days until 10/30/25, with the administrator and designees reviewing all updated assessments and ensuring follow-up care adjustments.

Proposed Overall Completion Date: 10/30/2025

Directed: In addition to the above plan of correction, the administrator or designee will ensure that Residents 5 & 7 are registered using their current address with local law enforcement as required by the Megan's Law registry requirements.

Directed Completion Date: 09/30/2025

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

227g -Support Plan Signatures

22. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #9's initial support plan completed [REDACTED] was not signed by the assessor.

Plan of Correction

Directed ([REDACTED]) - 09/15/2025

The administrator will ensure that all individuals participating in the development of a resident's support plan sign and date the plan in accordance with 2600.227g. For Resident #9, a designee will review the existing support plan and obtain the required signature and date from the assessor or individual responsible for development. If the signature is missing, the designee will immediately document the review, obtain the signature and date, and annotate the plan accordingly. The home will implement a protocol to double-check all support plans for proper signatures and dates prior to final approval, including a review checklist and supervisory sign-off process. The revised plan for Resident #9 will be completed with all signatures by 08/30/2025, and an audit of all support plans by 9/30/25.

Proposed Overall Completion Date: 09/30/2025

Directed: In addition to the above plan of correction, an audit will be completed on all Resident Assessment and Support Plan's to verify all required signatures are present. This will be documented with the date,

227g -Support Plan Signatures (continued)

resident RASP reviewed, person completing the review, and actions needed if any.

Directed Completion Date: 09/30/2025

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