pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **GREENFIELD OF PERKIOMEN VALLEY LLC**
LEGAL ENTITY

To operate **GREENFIELD OF PERKIOMEN VALLEY**
NAME OF FACILITY OR AGENCY

Located at **300 PERKIOMEN AVENUE, SCHWENKSVILLE, PA 19473**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **90**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 44**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **September 22, 2025** until **September 22, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **137350**

ISSUING OFFICER

DEPUTY SECRETARY

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

HS 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: September 22, 2025

Greenfield of Perkiomen Valley, LLC

RE: Greenfield of Perkiomen Valley
300 Perkiomen Avenue
Schwenksville, Pennsylvania 19473
License #: 137350

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on July 21 and 22, 2025, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY

September 9, 2025

GREENFIELD OF PERKIOMEN VALLEY LLC

RE: GREENFIELD OF PERKIOMEN VALLEY
300 PERKIOMEN AVENUE
SCHWENKSVILLE, PA, 19473
LICENSE/COC#: 13735

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/21/2025, 07/22/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *GREENFIELD OF PERKIOMEN VALLEY* **License #**: *13735* **License Expiration**: *09/21/2025*

Address: *300 PERKIOMEN AVENUE, SCHWENKSVILLE, PA 19473*

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

Administrator

Name:

Legal Entity

Name: *GREENFIELD OF PERKIOMEN VALLEY LLC*

Address:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/23/2012* **Issued By**: *Borough of Schwenksville*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Provisional, Incident* **Exit Conference Date**: *07/22/2025*

Inspection Dates and Department Representative

07/21/2025 - On-Site:

07/22/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *32*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory care* **Capacity**: *44* **Residents Served**: *5*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *32*

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

Have Mobility Need: *14* **Have Physical Disability**: *1*

Inspections / Reviews

07/21/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/22/2025*

08/26/2025 - POC Submission

Submitted By: **Date Submitted**: *09/05/2025*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/05/2025*

Inspections / Reviews *(continued)*

09/09/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *09/05/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

17 - Record Confidentiality

1. 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 7/21/2025, at 10:50 AM, resident records including shower schedules and assistance needs were unlocked, unattended, and accessible in a housekeeping closet in the memory care unit.

Repeat violation: 02/03/2025 et al

Plan of Correction ***Accept ██ - 08/26/2025)***

Executive Director Removed Resident records that included shower schedules and assistance needs on 7/23/2025. Resident Care Coordinator will start weekly Checks on 9/1/2025 for resident's records being locked in the appropriate offices, and continue the weekly checks for 4 weeks starting on 9/6/2025. Director of Nursing will educate care/med tech staff on proper record confidentiality and storage of these records on 8/28/2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented ██ - 09/09/2025)***

See attached.

18 - Compliance With Laws

2. Requirements

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

Description of Violation

On 7/21/2025 the fire extinguisher by the employee entrance parking lot was hung 5 ft and 9 inches off the ground.

NFPA § 50.71. Fire extinguishers- must be placed at max 5 feet by handle.

Plan of Correction ***Accept ██ - 08/26/2025)***

Maintenance Director Lowered the fire extinguisher by the employee entrance parking lot, by 10 inches to meet the requirement of 5 feet by the handle. Maintenance Director will measure all fire extinguisher on 9/1/2025 to ensure they are all place bellowed the max 5 feet by handle.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented ██ - 09/09/2025)***

See attached.

54a - Direct Care Staff

3. Requirements

54a - Direct Care Staff *(continued)*

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person, D does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Directed - 08/26/2025)***

For future new hires, prior to onboarding for the specified job, barring any new regulation or requirement, the executive director will collect a high school degree/ GED. The Executive director will start monthly audits for high school diplomas/GED for direct care staff employees starting on 9/1/2025, and continue monthly audits for 3 months.

Directed Plan of Correction (slw 8/26/25):
Staff D will be removed from the schedule until they can provide a high school diploma, GED certificate or a C.N.A. registry, effective immediately.

Proposed Overall Completion Date: 09/01/2025

Directed Completion Date: *09/01/2025*

Evidence of Completion ***Implemented - 09/09/2025)***

See attached.

81b - Resident Personal Equipment

4. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident 1 has a covered bedside mobility device. The device is not attached securely to the bed and creates a 5 in entrapment zone between the device and bed.

Plan of Correction ***Accept - 08/26/2025)***

Resident 1 was discharged on 025, and all of personal belongings were removed including the bedside mobility device on 8/4/2025. Executive Director will audit all occupied rooms monthly starting on 9/1/2025, to ensure if any of the residents have a bedside mobility device, that is is covered and secured to the be properly. Executive director will start this audit on 9/1/2025, and continue monthly checks for 3 months.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented - 09/09/2025)***

See attached.

82c - Locking Poisonous Materials

5. 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.

82c - Locking Poisonous Materials *(continued)*

Description of Violation

On 7/21/2025 Ecolution Pro Glass Cleaner, with a manufacture's label indicating "contact poison control center if ingested", was unlocked, unattended, and accessible to residents in the unlocked housekeeping closet in the memory care unit. Not all the residents of the home, including resident 2, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 08/26/2025)***

Executive Director removes the Ecolution pro glass cleaner from the housekeeping closet in the memory care unit on 7/22/2025. Executive director will educate housekeeping staff on 8/28/2025 on the importance of poisonous materials being locked in the housekeeping closets in the memory care unit. Director of Nursing will complete weekly checks for poisonous materials within memory care, to ensure that they are locked up accordingly starting on 9/1/2025, and continue these weekly checks for 4 weeks. Director of nursing will assess resident number 2 on 8/21/2025 for capability of recognizing and using poisons safely, and document it accordingly to the company's documentation standards.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented - 09/09/2025)***

See attached.

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

On 7/21/2025 trash and debris were found behind the washers and dryers in the laundry room across from 218.

At 11:01 AM red juice was spilled in the memory care refrigerator.

On 7/22/2025 at 10:27 AM there was a reddish-brown stain, possible feces or dried blood on the curtain covering the closet as well as reddish brown spots surrounding the bathroom sink in room 301.

At 10:38 AM the hoods in the kitchen had noticeable grease and grime build up. The hood had not been professionally cleaned since 11/15/2023.

Plan of Correction ***Directed - 08/26/2025)***

Maintenance director cleaned behind the washers and dryers in the laundry room on the 2nd floor on 8/14/2025. Maintenance director will educate housekeeping on 9/1/2025 to check behind the washers and dryer while cleaning the laundry rooms. Director of dining cleaned the red spill in memory care refrigerator on 7/23/2025. Director of dining will educate dietary staff on 9/1/2025 on sanitation and cleanliness. On 7/23/2025 Director of nursing cleaned the curtain covering the closet and cleaned around the sink on 7/25/25. Kitchen hoods were cleaned on 8/7/2025 by HOODZ cleaning company.

Directed Plan of Correction 8/26/25):

85a - Sanitary Conditions (continued)

Starting immediately, the maintenance director will conduct weekly physical site inspections of the home to identify problem areas to include cleanliness in resident rooms and laundry areas. Documentation of the weekly physical site inspections will be maintained for the Departments review for the next three months.
Proposed Overall Completion Date: 09/01/2025

Directed Completion Date: *09/01/2025*

Evidence of Completion ***Implemented ██ - 09/09/2025)***

See attached.

88a - Surfaces

7. 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 7/22/2025 the carpeting on the ramp leading to the second floor was dirty, torn and loose creating bubbles on the floor, which could be a tripping hazard.

Several pieces of railing were missing leaving no protective guarding between the first and second levels of the storage room located across from the maintenance room.

The latching hardware is missing from the fire doors latching located near the movie theater on the 3rd floor.

The latching hardware is missing from the fire doors located near room 119.

The fire doors at the top of the ramp near the employee entrance do not close and latch.

Plan of Correction ***Directed ██ - 08/26/2025)***

Housekeeping cleaned Ramp leading up to the 2nd floor on 7/22/2025. Maintenance director will get quotes for new carpet starting 9/1/2025, and have carpet replaced by 10/1/2025. Maintenance director will get quotes for the 2nd floor handrail, and have handrail fixed/replaced by 10/1/2025. The latching hardware for all of the fire doors will be fixed/replaced by 9/15/2025. VP of operations approved fire door repairs on 8/21/2025, and the parts and lead times is 6-8 weeks for repairs. All doors should be repaired/replaced by 10/1/2025
Directed Plan of Correction ██ 8/26/25):
Starting immediately, the maintenance director will conduct weekly physical site inspections of the home to identify problem areas to include cleanliness in resident rooms and laundry areas. Documentation of the weekly physical site inspections will be maintained for the Departments review for the next three months.
Proposed Overall Completion Date: 09/01/2025

Proposed Overall Completion Date: 09/01/2025

Directed Completion Date: *09/01/2025*

Evidence of Completion ***Implemented ██ - 09/09/2025)***

See attached.

96a - First Aid Kit

8. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the kitchen does not include a thermomter.

Plan of Correction ***Accept - 08/26/2025)***

On 7/22/2025 Executive director placed new thermometer into the kitchen first aid kit. Director of dining will do weekly checks starting 9/1/2025 for a completed first aid kit including gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye covering and tweezer, and continue the weekly checks for 4 weeks starting 9/1/2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented - 09/09/2025)***

See attached.

96b - First Aid Location

9. Requirements

2600.
96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

Staff person B, did not know the location of the first aid kit.

Plan of Correction ***Accept - 08/26/2025)***

Executive director will educate all staff on 8/28/2025 for the location and access to all of the first aid kits. Executive will hold random education/questioning staff members about the location of the first aid kits within the community starting on 9/1/2025, and continue weekly for 3 weeks.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented (- 09/09/2025)***

See attached.

100a - Exterior - Free of Hazards

10. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 7/21/2025 weeds were growing through the cracks of the memory care unit outside seating area, creating a potential tripping hazard.

Repeat violation: 10/16/2024, 09/11/2024 et al

Plan of Correction ***Accept (- 08/26/2025)***

Maintenance director weed wacked the memory care unit outside seating area on 8/12/2025. Maintenance director trimmed the walkways in the memory care courtyard on 8/12/2025. Maintenance director will complete weekly

100a - Exterior - Free of Hazards (continued)

checks on the memory care courtyard starting 9/1/2025, to ensure there is no overgrown weeds on the paths or sitting area, and continue weekly checks for 4 weeks starting on 9/1/2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented (- 09/09/2025)***

See attached.

11. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 7/22/2025, on the outside of the building near the maintenance door fire exit, there was an unblocked staircase next to "the pool" maintenance area. On the stairs there was a wooden slide leading below ground level. At the bottom of the slide were trash, leaves and animals could be heard moving around.

Near the entrance leading to the smoking area, there was multiple areas where large chunks of the concrete were missing. Weeds were growing up through the areas of missing concrete, creating a potential tripping hazard.

Plan of Correction ***Accept (- 08/26/2025)***

Maintenance director started to get quotes on 8/1/2025 for the concrete repair in the rear of the building. Weeds were removed from in between the cracks on 8/1/2025 by maintenance Director. Director of maintenance will clean out the unblocked staircase on 9/5/2025. Maintenance director will do weekly audits of all outside stairwells to ensure there is no trash and or Debri starting on 9/5/2025, and continue weekly checks for 4 weeks thereafter.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented (- 09/09/2025)***

See attached.

101j3 - Bed/Linens/Pillows/Blankets

12. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 7/22/2025 at 10:21 AM the bed for resident 3 did not have sheets and a blanket.

Plan of Correction ***Accept (- 08/26/2025)***

After resident 3's laundry was completed, Care staff re-made the bed with clean sheets and a blanket on 7/22/2025. RCC will educate care staff on 8/28/2025 in cleanliness of pillows, bed linens and blankets that are in good repair. RCC will audit all occupied rooms on 9/1/2025 to ensure that all beds are made and sheets and blankets are in good repair. RCC will continue this audit weekly for 4 weeks starting on 9/1/2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented (- 09/09/2025)***

See attached.

102h - Toilet Paper

13. Requirements

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

Description of Violation

On 7/22/2025 at 10:21 AM, there was no toilet paper for the toilet in the bathroom of room 309.

Plan of Correction ***Accept (- 08/26/2025)***

Housekeeping placed toilet paper roll in room 309 on 7/22/2025. Housekeeping will do daily bathroom checks starting 9/1/2025 to ensure all resident bathrooms have toilet paper stocked for use, and continue daily bathroom checks for 3 weeks starting on 9/1/2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented - 09/09/2025)***

See attached.

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

On 7/21/2025 at 11:01 AM the temperature in the memory care unit freezer was 3 degrees Fahrenheit,

Repeat violation: 02/03/2025 et al

Plan of Correction ***Accept - 08/26/2025)***

Director of dining placed new thermometer in memory care freezer on 7/22/2025, resulting in proper temperature readings less the zero degree. Director of dining will educate all dietary staff on proper temperature recordings for refrigerators within the memory care unit on 8/28/2025. Director of dining complete weekly temperature audits for the memory care freezer starting 9/1/2025 and continue weekly checks for 4 weeks.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented - 09/09/2025)***

See attached.

105f - Labeling/Return of Clothes

15. Requirements

2600.
105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

Description of Violation

Ther was a cabinet labeled employees only in laundry room outside of room 122 was full of what seemed to be various residents clothing- none of this clothing was labeled with a name or room number.

Plan of Correction ***Accept - 08/26/2025)***

Resident care coordinator will re-label cabinet for lost and found clothing on 8/27/2025. Resident care coordinator

105f - Labeling/Return of Clothes (continued)

will return missing clothing to the residents by 9/1/2025. Executive director will educate care staff on 8/28/2025 of labeling/returning of clothing within 24 hours after laundering. Resident care coordinator will audit cabinet weekly starting 9/1/2025 for 4 weeks ensuring there is no missing clothing within the cabinet.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented - 09/09/2025)***

See attached.

107d - Procedure Emergency Management Agency Submission

16. 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 submitted on 7/21/2025. The home could not provide proof of a prior submission.

Plan of Correction ***Accept - 08/26/2025)***

Executive director was educated on 7/21/2025 from the department about yearly submission of emergency management.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented 09/09/2025)***

See attached.

121a - Unobstructed Egress

17. 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 7/21/2025 the emergency exit gate from the memory care patio required extensive force to open. The gate could not be closed without sufficient force.

Plan of Correction ***Accept - 08/26/2025)***

Director of maintenance received quote for memory care emergency exit on 8/19/2025. Planning on having the memory care gate repaired by 10/1/2025. Director of maintenance will do weekly checks for all emergency exits starting on 9/1/2025 to ensure that there are no unobstructed egress, and continue these checks weekly for 4 weeks.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented - 09/09/2025)***

See attached.

181c - Self-administration Assessment

18. Requirements

2600.

181c - Self-administration Assessment *(continued)*

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident 4 self-administers medications to include Nystop powder, which [redacted] applies to [redacted] legs once a day. Directions for this medication are to apply topically to reddened area under bilateral breast twice a day; however, resident 4 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Directed [redacted] - 08/26/2025)***

Resident 4 has an order dated 6/4/2025 "May keep at bedside and self-administer for anti fungal cream". Resident will be re-evaluated by pcp on 8/28/2025.

Directed Plan of Correction [redacted] 8/26/25):
In addition to the step noted the administrator will schedule or conduct an audit of all residents that self-administer medications to ensure the resident has been assessed for the ability to self-administer medications, within the next 30 days.

Proposed Overall Completion Date: 09/01/2025

Directed Completion Date: *09/01/2025*

Evidence of Completion ***Implemented [redacted] - 09/09/2025)***

See attached.

181f - Record of Medication

19. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 7/22/2025, resident 1's record did not include a current list of medications. The list in the resident's record did not include CBD gummies and acetaminophen 500 mg capsules.

Resident 5's record did not include a current list of medications. The list in the resident's record did not include fenofibrate 48 mg, and pantoprazole 40 mg.

Plan of Correction ***Accept [redacted] - 08/26/2025)***

Resident 1 was discharged on [redacted]/2025. Director of nursing will audit all current residents med lists on 8/27/2025 to ensure that all medications in house are on the proper forms. Director of nursing will continue this audit weekly for 4 weeks.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented [redacted] - 09/09/2025)***

See attached.

182b - Prescription Medication

20. 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.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 7/1, and 7/8-7/15 at 8 AM staff person C administered medications to residents to include the following; Eliquis 5 mg tablet, Ferrosol 325 mg tablet, and memantine 10 mg tablet to resident 2 . Staff person C is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

The staff person did complete medication administration training on 2/3/2025, however the trainer who completed the training was did not meet the required qualifications of the department's "Train the Trainer" certification. The trainer was not employed at a licensed facility at the time of the training; therefore, staff person C's training is invalid.

Plan of Correction ***Accept [redacted] - 08/26/2025)***

Executive director reached out to previous train the trainer on 7/22/2025 to obtain paperwork to prove validation of credential. Train the trainer states he has the updated paperwork, and ED is still waiting for copies of these documents. Director of nursing become a certified train the trainer on 8/13/2025. Director of nursing will re-certify staff person C on 8/29/2025 and will review all med tech training for completeness.

Proposed Overall Completion Date: 09/01/2025

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented [redacted] - 09/09/2025)***

See attached.

183a - Original Containers and Injections

21. 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 7/22/2025 at 10:10, Nystop powder for resident 4 was in a medication cup on [redacted] bedside table. During an interview, resident 4 said that staff members give [redacted] a medication cup of the powder which resident 4 then uses for multiple applications across multiple days.

183a - Original Containers and Injections *(continued)*

Plan of Correction ***Directed (- 08/26/2025)***

Director of nursing removed nystop powder from resident 4's bedside table on 7/22/2025.RCC will educate med techs on 8/28/2025 on proper medication administration timeframes.

Directed Plan of Correction 8/26/25):
The DON will conduct random checks of resident rooms, at least bi-weekly, to ensure all medication is administered according to the prescription, starting immediately.

Proposed Overall Completion Date: 09/01/2025

Directed Completion Date: *09/01/2025*

Evidence of Completion ***Implemented - 09/09/2025)***

See attached.

183b - Meds and Syringes Locked

22. 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 7/22/2025 at 10:10 AM, Baza anti-fungial cream 2% was unlocked, unattended, and accessible in in the bathroom of room 215.

Plan of Correction ***Directed - 08/26/2025)***

Director of nursing removed anti-fungial cream from the bathroom of 215, and placed in med cart for proper storage on 7/22/2025.RCC will educate med techs on 8/28/2025 on proper medication and syringe storage.

Directed Plan of Correction (slw 8/26/25):

The DON will conduct random checks of resident rooms, at least bi-weekly, to ensure all medication is administered according to the prescription, starting immediately.

Proposed Overall Completion Date: 09/01/2025

Directed Completion Date: *09/01/2025*

Evidence of Completion ***Implemented (- 09/09/2025)***

See attached.

183e - Storing Medications

23. 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.

183e - Storing Medications *(continued)*

Description of Violation

On 7/22/2025 Milk of Magnesia which was opened on 11/10/2024, was in the home's medication cart. According to the manufacturer's instructions this should be discarded 6 months after opening.

Resident 6's blister pack of loperamide 2 mg capsules was completely torn at pill 14. The slot was taped over, and the capsule was stuck to the tape.

Repeat violation: 02/03/2025 et al, 11/13/2024

Plan of Correction ***Accept - 08/26/2025)***

Milk of magnesia was discarded by DON on 7/22/2025. DON properly destroyed resident 6's medication immediately 7/22/2025. Resident care coordinator will educate med tech on proper medication storage on 8/26/2025. Resident care coordinator will complete weekly med cart audits starting on 9/1/2025, and continue weekly for 4 weeks after the start date of 9/1/2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented - 09/09/2025)***

See attached.

185a - Implement Storage Procedures

24. 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 7/14/2024 at 7:43 AM resident 7's glucometer had a reading of 259, however it was transcribed in resident 7's 7/2025 medication administration record as 254.

Repeat violation: 04/10/2025, 02/03/2025 et al, 11/13/2024

Plan of Correction ***Accept - 08/26/2025)***

Director of nursing will complete weekly glucometer audits starting 9/1/2025, and continue weekly for 4 weeks thereafter. Resident care coordinator will educate med tech on proper glucometer readings and transcription on 8/26/2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented - 09/09/2025)***

See attached.

187d - Follow Prescriber's Orders

25. Requirements

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

Description of Violation

Resident 8 is prescribed Levothyroxine tab 125 mcg, take one tablet by mouth daily for hypothyroidism. However, resident 8 was not administered this medication on 7/21/2025.

187d - Follow Prescriber's Orders (continued)

Repeat violation: 02/03/2025 et al

Plan of Correction ***Directed (- 08/26/2025)***

Resident care coordinator will educate med techs on 8/28/2025, on proper medication administration and how to properly follow prescriber's order.

Directed Plan of Correction (slw 8/26/25):
In addition to the step noted, the RCC will conduct weekly audits of the MARs to ensure all medications have been administered and if not, was the resident's physician contacted for instructions, starting immediately.

Proposed Overall Completion Date: 09/01/2025

Directed Completion Date: *09/01/2025*

Evidence of Completion ***Implemented (- 09/09/2025)***

See attached.

226a - Mobility Assessment

26. Requirements

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident 1's assessment, dated /2025, includes that resident 1 uses a bedside mobility device by choice.

When bedside mobility devices are being used, the Resident Support Plan must reflect:
The specific need for the device,
The intended Use,
Any risks associated with the device,
The resident's ability to use the device safely for the intended purpose,
Identification of the specific device to be used,
If a cover is required to meet FDA guidelines.

Plan of Correction ***Accept (- 08/26/2025)***

Resident 1 moved out on /2025. Director of nursing was educated by the Executive director on 7/23/2025 about the proper documentation for residents with mobility devices, and how it needs to be written in the support plan.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented (- 09/09/2025)***

See attached.

227c - Support Plan Revision

27. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

227c - Support Plan Revision *(continued)*

Description of Violation

Resident 9's assessment was completed on [redacted]/2025; however, the resident's began exhibiting increased episodes of confusion and anxiety on 5/31/2025. On 7/5/2025 resident 9 exited the facility and began yelling at passing cars. No revision was completed on the resident's assessment and support plan.

Plan of Correction ***Accept [redacted] - 08/26/2025)***

Resident 9 was re-assessed on [redacted] for change in condition. Resident went out on [redacted] on 8/11/2025, and will not be returning due to the need for long term care. Executive Director will educate Director of nursing and RCC on timeliness on assessments upon changes in the resident's needs on 8/26/2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented [redacted] - 09/09/2025)***

See attached.

227d - Support Plan Medical/Dental

28. 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

The assessment for resident 9, dated [redacted]2025, indicates the resident has needs for assistance including with transferring, toileting, extensive supervision, administering medications and that the resident is totally immobile. The resident's support plan dated [redacted]/2025 does not document how these, or any other needs will be met. The resident's support plan only shows indication of a degree codes. In the area provided for description of needs and how the needs will be met was completely blank.

Plan of Correction ***Accept [redacted] - 08/26/2025)***

Resident went out on [redacted] on [redacted]/2025, and will not be returning due to the need for long term care. Director of nursing will audit all support plans monthly starting on 9/1/2025, and continue for 4 months beginning 9/1/2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented [redacted] - 09/09/2025)***

See attached.

227g -Support Plan Signatures

29. 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 10 participated in the development of [redacted] support plan on [redacted]/2025. However, the resident did not sign the support plan.

Plan of Correction ***Accept [redacted] - 08/26/2025)***

Director of nursing had resident 10 sign [redacted] support plan on [redacted]/2025. Director of nursing will start monthly

227g -Support Plan Signatures (continued)

support plan audits starting 9/1/2025 to ensure all support plans are signed by the resident or [redacted] if applicable, and continue monthly audits for 4 months starting 9/1/2025.

Licensee's Proposed Overall Completion Date: *09/01/2025*

Evidence of Completion ***Implemented [redacted] - 09/09/2025)***

See attached.