Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

September 4, 2025

REGIONAL DIRECTOR OF OPERATIONS
SZR GRANITE RUN AL OPCO LLC

RE: SUNRISE OF GRANITE RUN
247 NORTH MIDDLETOWN ROAD
MEDIA, PA, 19063
LICENSE/COC#: 14490

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: *SUNRISE OF GRANITE RUN* **License #**: *14490* **License Expiration**: *01/01/2026*

Address: *247 NORTH MIDDLETOWN ROAD, MEDIA, PA 19063*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SZR GRANITE RUN AL OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *09/09/1998* **Issued By**: *Middletown Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *140* **Waking Staff**: *105*

Inspection Information

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

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

Inspection Dates and Department Representative

07/21/2025 - On-Site: [redacted]

07/22/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *83*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reminiscence* **Capacity**: *38* **Residents Served**: *32*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *83*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *57* **Have Physical Disability**: *0*

Inspections / Reviews

07/21/2025 - Full

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

08/15/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/04/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/08/2025*

Inspections / Reviews *(continued)*

09/04/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *09/04/2025*
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 9:45 am, a laptop on top of a second-floor medication cart was open, displaying prescriptions and other health information about resident #1. At 9:50 am, there were two laptops on top of med carts in the Secure Dementia Care Unit (SDCU) both open to the healthcare platform Point Click Care, with health information of residents accessible . At 9:55 am, the office of staff person A was unlocked, with binders marked "room audit binder" and "signed assignment sheets," containing private information about residents care in the SDCU unattended and accessible.

Plan of Correction ***Accept ([redacted] - 08/15/2025)***

On 7/21/2025, Medication Care Manager (MCM) immediately closed additional tabs on top of laptop screen that were opened to ensure that residents health information was not accessible.

On 7/21/2025 Reminiscence Supervisor (RS) immediately locked the office doors where resident information was stored.

On 7/21/2025, a secured and lockable filing cabinet was ordered for this office to ensure that all documents containing private information about resident's care in SDCU are secured and private.

On 7/21/2025, the Resident Care Director (RCD) walked the community to ensure that pertinent health information was not accessible on other laptops in public areas.

On 7/22/2025, RCD conducted retraining for Wellness Nurses (WNs) and MCMs to ensure resident information is kept confidential while using the laptops on the medication carts, including confirmation that additional tabs are closed in top of the laptop. RS met with direct care staff to ensure that RS's office door remains closed and locked when the office is not occupied by staff members.

Starting 8/1/2025 and for a period of 60 days, weekly checks will be conducted by RCD to ensure privacy and security of residents' information while using the Medication Cart Laptops.

Starting 8/1/2025 and for a period of 60 days, ED will conduct weekly checks to ensure that the door to the RS's office is secured and all information about resident's care in the SDCU remains private.
Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the Executive Director and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - [redacted] 8/15/25.

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

17 - Record Confidentiality *(continued)*

Implemented (█ - 09/04/2025)

23a - Activities of Daily Living Assistance

2. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan for resident #2 indicates the resident requires the assistance of two people with transferring. On 6/26/2025 at approximately 2:50 pm, staff person B attempted to transfer resident #2 solo from a wheelchair to a lounge chair in the hallway between the resident's room and the dining room of the Secure Dementia Care Unit. Resident #2 suffered a displaced left fibular ankle fracture during this transfer and required hospital treatment.

Plan of Correction ***Accept (█ - 08/15/2025)***

On 6/27/2025, an internal investigation was conducted by the Executive Director (ED) into this incident.

On 7/29/2025, upon receiving DHS violation report, ED and Resident Care Coordinator (RCC) conducted a retraining to ensure that staff are providing each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

On 7/31/2025, ED, RCC and Resident Care Director (RCD) conducted an audit for all falls in the community in the past 3 months to ensure that no other falls occurred due to the same reason.

Starting 8/1/2025 and for a period of 60 days, RCD will conduct monthly checks to ensure that no other falls occurred due to the same reason.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - █ 8/15/25.

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

Implemented (█ - 09/04/2025)

41c - Rights Poster

3. Requirements

2600.
41.c. The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the home.

41c - Rights Poster *(continued)*

Description of Violation

On the morning of 7/21/2025, the Department's resident's rights poster was not posted in a conspicuous and public place in the home's Secure Dementia Care Unit.

Plan of Correction ***Accept (- 08/15/2025)***

On 7/21/2025 Reminiscence Supervisor (RS) immediately placed posters of Resident Rights in 2 locations of common area entrances of the SDCU. The Resident Care Coordinator (RCC) and RS walked the entire community to ensure that Resident Rights posters are posted in a conspicuous and public place in the home.

On 7/23/2025, the Executive Director (ED) conducted retraining with the coordinator team to ensure Resident Rights posters are posted in a conspicuous and public place in both Personal Care and SDCU.

Starting 8/1/2025 and for a period of 60 days, RCC, RS and Lead Care Managers (LCM) will conduct weekly visual checks to ensure Resident Rights posters remain posted in a conspicuous and public place in both Personal Care and SDCU.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - 8/15/25.

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

Implemented (- 09/04/2025)

54a - Direct Care Staff

4. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person C does not have a high school diploma from the United States, GED, or active registry status on the Pennsylvania nurse aide registry. The staff person has a high school diploma from

Plan of Correction ***Accept (- 08/15/2025)***

On Direct care staff person (C) was removed from the schedule and placed on administrative leave.

On 7/24/2025, a "Request for Waiver Regulation" was submitted by Executive Director (ED) to PA Department of Human Services Licensing regarding direct care staff person (C) high school diploma.

54a - Direct Care Staff (continued)

On 7/29/2025, the ED conducted retraining with the Business Office Coordinator (BOC) to ensure Direct Care Staff Persons meet the qualifications required by the department in the corresponding regulations.

On 7/30/2025, the BOC conducted an audit for all community employee files to ensure that Direct Care Staff Persons meet the qualifications required by the department in the corresponding regulations.

Starting 8/1/2025, the BOC will conduct a weekly check of New Team Members files hired that week to ensure continued compliance with this regulation.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - [redacted] 8/15/25.

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

Implemented ([redacted] - 09/04/2025)

65g - Annual Training Content

5. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person D did not receive training in fire safety during training year 2024.

Plan of Correction ***Accept ([redacted] - 08/15/2025)***

On [redacted], direct care staff person (D) was terminated for failure to report to work.

On 7/30/2025, an audit of the 2024 fire safety training log was conducted by the Business Office Coordinator (BOC) to determine if all employees completed the in-person fire safety training in 2024.

On 7/31/2025 Maintenance Assistant (MA) and BOC attended Fire Safety: Train the Trainer class on 7/31/2025.

Starting 8/1/2025, the BOC will conduct monthly audits for a period of 60 days to ensure all staff persons received training in fire safety and continued compliance with this regulation.

65g - Annual Training Content (continued)

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - ██ 8/15/25.

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

Implemented (██ - 09/04/2025)

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

On 7/21/2025 at 9:37 am, stairwell D on the second floor was littered with white debris from sheetrock scattered over the carpet.

Plan of Correction ***Accept (██ - 08/15/2025)***

On 7/21/25 Area Facilities Manager (AFM) immediately cleaned the carpet and cleared debris in stairwell D. AFM then checked all remaining stairwells in the community to ensure that sanitary conditions were maintained.

On 7/29/2025, the Executive Director (ED) conducted a retraining with Housekeeping and Maintenance Staff Members to ensure that sanitary conditions are being maintained and that all stairwells are clean and free of debris.

Starting 8/1/2025, and for a period of 60 days, a representative from the maintenance department will conduct weekly checks of community stairwells to ensure that they remain clean and free of debris.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - ██ 8/15/25.

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

Implemented (██ - 09/04/2025)

85e - Trash Outside Home

7. Requirements

2600.

85e - Trash Outside Home *(continued)*

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

Description of Violation

On 7/21/2025 at 10:03 am, one of the home's dumpsters was open, with several cardboard boxes and a white bag inside. A wheelchair, wooden bureau, and cardboard box were discarded on the ground next to the dumpster.

Plan of Correction ***Accept (- 08/15/2025)***

On 7/21/2025 at approximately 10:30 AM, Area Facilities Manager (AFM) removed trash items from around the dumpsters and enclosure, placed them into the dumpsters, secured dumpster lids, and closed/secured dumpster enclosure gate.

On 7/22/2025, the AFM contacted trash/recycling vendor to request that their drivers close every dumpster lid and enclosure gate at the conclusion of every trash or recycling pickup visit.

On 7/24/2025, the Executive Director (ED) and AFM conducted a retraining of all housekeeping and maintenance staff persons to ensure that dumpster lids and enclosure gates are closed at all times when trash/recycling is not being disposed of to prevent the penetration of insects and rodents.

Starting 8/1/2025 and for a duration of 60 days, a representative of the maintenance team will inspect the dumpster enclosure area daily to ensure that trash dumpsters are covered to prevent the penetration of insects and rodents and the area around the receptacles is clean.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - 8/15/25.

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

Implemented (- 09/04/2025)

86b - Bathroom

8. 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

On 7/22/2025, the bathrooms in rooms 102 and 110 did not have an operable window or ventilation fan. The vents in these bathrooms were inoperable.

Plan of Correction ***Accept (- 08/15/2025)***

On 7/22/2025, Area Facilities Manager (AFM) conducted an inspection of all rooftop ventilation fans immediately after the discovery of the inoperable bathroom ventilation fan and concluded that only 1 fan was inoperable and

86b - Bathroom (continued)

needed a replacement motor.

On 7/23/2025, AFM ordered the replacement parts needed to repair the inoperable fan.

On 7/29/2025, Maintenance Assistant (MA) received the parts ordered, replaced the motor on the inoperable exhaust fan and tested the affected bathrooms to ensure proper operation.

Starting 8/1/2025 and for a period of 60 days, a representative from the maintenance department will conduct weekly checks of all roof top bathroom exhaust fans to ensure that all bathrooms without outside windows shall be equipped with an operable exhaust fan for ventilation.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - ███ 8/15/25.

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

Implemented (███ - 09/04/2025)

88a - Surfaces

9. 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 inside of the ice machine in the main kitchen was streaked with a yellow-brown substance.

Plan of Correction ***Accept (███ - 08/15/2025)***

On 7/22/2025, immediately after discovery, the Executive Director (ED) wiped the residue clean from the ice machine. Dietary staff persons were instructed to conduct an immediate and thorough cleaning of the ice machine. The ice machine was completely emptied out and sanitized as part of the kitchen closing procedure for that day.

On 7/28/2025, the ED conducted a retraining for dietary staff persons to ensure that all surfaces be clean, in good repair, free of hazards, and that the ice machine is cleaned and monitored regularly.

Starting 8/1/2025 and for a period of 60 days, a representative of the dietary team will conduct weekly checks to ensure that the ice machine remains clean, in good repair and free of hazards.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

88a - Surfaces (continued)

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - ██ 8/15/25.

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

Implemented (██ - 09/04/2025)

89b - Hot Water Temperature

10. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 7/22/2025 at 11:05 am, the hot water temperature in the bathroom sink of room 252 measured 123 degrees Fahrenheit. At 11:15, the hot water temperature in the bathroom sink of room 238 was 122 degrees Fahrenheit.

Plan of Correction ***Accept (██ - 08/15/2025)***

On 7/23/2025, Area Facilities Manager (AFM) reduced boiler temperature by 3 degrees to ensure that hot water temperature in area accessible to the residents does not exceed 120 degrees F.

On 7/24/2025, the AFM conducted a check to confirm that the temperature of hot water in areas accessible to the residents may not exceed 120 degrees F.

Starting 8/1/2025 and for a period of 60 days, a representative from the maintenance department will conduct checks 3 times per week of representative samples of all areas accessible by residents that contain hot water to ensure that hot water temperature may not exceed 120 degrees F.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - ██ 8/15/25.

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

Implemented (██ - 09/04/2025)

95 - Furniture and Equipment

11. Requirements

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

95 - Furniture and Equipment *(continued)*

Description of Violation

From 7/21/2025 at 9:00 am to 7/22/25 at 12:45 pm, a pathway light fixture was overturned and lying sideways on the ground in front of the home's front porch.

Plan of Correction ***Accept (- 08/15/2025)***

On 7/23/2025, the Executive Director (ED) and Area Facilities Manager (AFM) conducted a visual inspection of the exterior light fixtures to ensure that the remaining exterior lights are in good repair.

On 7/25/2025, the AFM reached out to multiple landscaping and electrical contractors to request on site quotes for the repairs needed for the exterior light.

By approximately 8/22/2025, the community anticipates all repair quotes from vendors and local contractors to be received, and a purchase order requisition for the repairs will be submitted for financial approval by ED.

By approximately by 9/26/2025, the community anticipates a contractor to be selected and the purchase order for the repair to be approved and an installation start date would be provided to the community.

Starting 11/1/2025 or upon completion of the repair and for a period of 60 days, a representative from the maintenance department will conduct weekly checks of all exterior lights to ensure that all lights are operable and in good repair.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - 8/15/25.

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

Implemented (- 09/04/2025)

101j7 - Lighting/Operable Lamp

12. 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 7/22/2025, the resident in room 102 did not have access to a source of light that could be turned on/off at bedside.

Plan of Correction ***Accept (- 08/15/2025)***

On 7/22/2025, the Resident Care Coordinator (RCC) immediately replaced the bedside lamp next to the resident bed. RCC and Reminiscence Supervisor (RS) walked the community to ensure that all occupied resident rooms have an operable lamp that can be turned on at bedside.

On 7/23/2025, the resident was provided with a push light that is mounted to bedside table to ensure that an

101j7 - Lighting/Operable Lamp (continued)

operable lamp can be turned on at bedside.

On 7/31/2025, the Executive Director (ED) conducted a retraining for care coordinators and lead care managers to ensure that an operable lamp can be turned on at bedside.

On 8/1/2025 and for a period of 60 days, care coordinators will conduct a weekly audit of all occupied resident rooms at the community to ensure that an operable lamp can be turned on at bedside and replace any missing or inoperable bedside lights.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - █ 8/15/25.

Licensee's Proposed Overall Completion Date: *10/01/2025*

Implemented (█ - 09/04/2025)

125a - Combustible Storage

13. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 7/21/2025 at approximately 10:10 am, there was clothing and other debris on the floor behind the washing machines and dryers in the second-floor laundry room.

Plan of Correction ***Accept (█ - 08/15/2025)***

On 7/21/2025, immediately after the discovery, the pants located behind the dryer were removed and the area behind the dryers was cleaned and cleared of all debris.

On 7/21/2025, the Resident Care Coordinator (RCC) conducted a laundry room check to ensure all laundry rooms, washers and dryers are free from clutter, combustible or flammable materials near heat sources.

On 7/22/2025 the RCC conducted a retraining of direct care staff to ensure that combustible and flammable materials may not be located near heat sources or hot water heaters and that laundry rooms remain clean and free of debris and loose items.

Starting 8/1/2025 and for a period of 60 days, a coordinator or lead care manager will conduct weekly checks of all laundry rooms at the community to ensure that combustible and flammable materials are not located near a heat source.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and

125a - Combustible Storage (continued)

evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - █ 8/15/25.25

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

Implemented (█ - 09/04/2025)

132d - Evacuation

14. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 5/14/2025 at 9:00 PM, the home took 15 minutes and 40 seconds to evacuate. The home received a maximum safe evacuation time by a fire safety expert of 15 minutes on 4/21/25.

Plan of Correction ***Accept (█ - 08/15/2025)***

On 5/21/2025, a repeat fire drill was conducted 7 days after the failed drill. The community team successfully executed a second fire drill under the maximum time specified by the safety expert.

On 7/31/2025, the Executive Director (ED) initiated retraining for the coordinator team and the maintenance staff persons to ensure that residents are able to evacuate the entire building within the time designated by the fire safety expert.

On 7/31/2025 Maintenance Assistant (MA) and Business Office Coordinator (BOC) attended Fire Safety: Train the Trainer class to increase fire safety awareness at the community

On 8/4/2025, the AFM conducted an audit of the fire drill records to ensure that all other fire drills for the past 6 months were completed within the time designated by the fire safety expert.

On 8/4/2025, the ED held a tabletop discussion with the coordinator team to determine the root cause analysis that resulted in exceeding the maximum time specified by the safety expert.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - █ 8/15/25.

132d - Evacuation *(continued)*

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

Implemented (- 09/04/2025)

185a - Implement Storage Procedures

15. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #3 is prescribed 0.25 ML of morphine sulphate concentrate every six hours as needed. On 7/22/2025, the home had 20 syringes on hand for resident #3, but the narcotics log said there were only 10.

Plan of Correction ***Accept (- 08/15/2025)***

On 7/22/2025 the Resident Care Director (RCD) immediately conducted a medication recount for Resident #3 morphine syringes to ensure that the record reflects the correct count on hand.

On 7/24/2025, the Executive Director (ED) and RCD conducted a retraining for all Medication Care Managers (MCM) and Wellness Nurses (WN) to ensure that proper procedures for the safe storage, access, security, distribution and use of medication and medical equipment are being followed by trained staff persons.

On 7/29/2025, the RCD conducted an audit for all the medication carts at the community to ensure that proper procedures for the safe storage, access, security, distribution and use of medication and medical equipment are being followed by trained staff persons.

Starting 8/1/2025 and for a period of 60 days, the RCD will conduct a weekly audit of a sample cart to ensure that proper procedures for the safe storage, access, security, distribution and use of medication and medical equipment are being followed by trained staff persons.

Starting 8/1/2025 for 2 QAPI meetings, the Plan of Corrections (POC) and monitoring results will be reviewed and evaluated by the ED and coordinators at the Quality Assurance and Performance Improvement (QAPI) meeting to ensure it is still effective. If it is no longer effective, it will be amended and a new POC will be implemented and monitored to ensure the violation does not occur again.

Directed to change proposed overall completion date only- changed to 9/1/25 to be in line with training and audit time lines indicated in acceptable POC. - 8/15/25.

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

Implemented (- 09/04/2025)