pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **JUNIPER VILLAGE AT MONROEVILLE LLC**
LEGAL ENTITY

To operate **JUNIPER VILLAGE AT MONROEVILLE**
NAME OF FACILITY OR AGENCY

Located at **2589 MOSSIDE BOULEVARD, MONROEVILLE, PA 15146**
(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 **126**
(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 21**

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 **December 8, 2025** until **December 8, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **452630**

ISSUING OFFICER

Juliet Marsala
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: December 8, 2025

[redacted]
Juniper Village at Monroeville, LLC
2589 Mosside Boulevard
Monroeville, PA 15146

RE: Juniper Village at Monroeville
License #: 45263

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on July 21, 2025, July 22, 2025, August 28, 2025, September 10, 2025 and December 1, 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

Bureau of Human Services Licensing
555 Walnut Street, Forum Place, 6th Floor | Harrisburg, PA 17101 | 717.783.3670 | F 717.783.5662 | www.dhs.pa.gov

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

Facility Information

Name: *JUNIPER VILLAGE AT MONROEVILLE* **License #**: *45263* **License Expiration**: *10/18/2025*

Address: *2589 MOSSIDE BOULEVARD, MONROEVILLE, PA 15146*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name:

Legal Entity

Name: *JUNIPER VILLAGE AT MONROEVILLE LLC*

Address: *2589 MOSSIDE BOULEVARD, MONROEVILLE, PA, 15146*

Phone:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *02/14/1997* **Issued By**: *Labor and Industry*

Type: *I-2* **Date**: *05/30/1997* **Issued By**: *Municipality of Monroeville*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *96* **Waking Staff**: *72*

Inspection Information

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

Reason: *Renewal, Provisional* **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: *126* **Residents Served**: *66*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Wellsprings* **Capacity**: *21* **Residents Served**: *16*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *66*

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

Have Mobility Need: *30* **Have Physical Disability**: *1*

Inspections / Reviews

07/21/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/21/2025*

08/25/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/25/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/29/2025*

09/02/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/25/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/25/2025*

12/02/2025 - Document Submission

Submitted [redacted] **Date Submitted**: *09/25/2025*

Reviewer: [redacted] **Follow-Up Type**: *Exception*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 7/21/25, a copy of the 55 Pa. Code, Chapter 2600 personal care home regulations were secured in a cabinet behind the main entrance reception area and were not posted in a conspicuous and public place in the home.

Plan of Correction ***Directed ███ - 09/02/2025)***

Copy of the 55 1pa. Code, Chapter 2600 personal care home regulations was immediately posted in the binder with current license and inspection summaries.

Binder will posted at the front desk at all times and available for public view.

Compliance will be assured with use of rounds checklist that is to be completed by ED/MOD or designee daily x 1 mth then weekly beginning 7/29/25.

Compliance to be included in monthly QI meetings. See attached (DIRECTED: By 9/25/25: The home shall conduct a quality management review, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. ███ 9/2/25).

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/25/2025*

Implemented ███ - 12/02/2025)

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 7/21/25 at approximately 11:00AM, the privacy coding document from the 4/17/24, et. al. inspection, which contained 11 resident names, including resident #5, was posted in a binder and unattended on the desk of the main entrance reception area.

REPEAT VIOLATION: 4/17/2024, et. al.

Plan of Correction ***Directed ███ - 09/02/2025)***

Privacy coding was immediately removed.

Compliance will be assured with use of rounds checklist that is to be completed by ED/MOD or designee daily x 1 mth then weekly beginning 7/29/25. (see attachment 3C)

17 - Record Confidentiality (continued)

All Staff will be re-educated on resident records confidentiality by 9/1-/25. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. ███ 9/2/25). Education to be conducted by ED/designee. See attached education

Proposed Overall Completion Date: 09/10/2025

Directed Completion Date: *09/02/2025*

Implemented ███ - 12/02/2025)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Direct care staff person A, hired on ███/21, did not receive training on instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during the 2024 training year.

Direct care staff person B, hired on ███/21, did not receive training on instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during the 2024 training year.

REPEAT VIOLATION: 4/17/2024, et. al.

Plan of Correction ***Directed (███ - 09/02/2025)***

All direct care staff will be re-educated on preadmission screening form, assessment tool, medical evaluation and support plan By September 10th. (DIRECTED: Documentation of all staff education shall be kept in accordance with 2600.65i, including the documentation of staff education for staff persons A and B. ███ 9/2/25). This additional training will be done upon hire then annually moving forward.

DIRECTED: Beginning on 9/25/25: The administrator/designee shall review all staff person trainings, as well as the home's staff training plan, each month to ensure all direct care staff persons receive training on all topics specified in 2600.64f during each training year. ███ 9/2/25).

65f - Training Topics (continued)

Education will be done by ED or designee (see attached)

Proposed Overall Completion Date: 09/10/2025

Directed Completion Date: *09/25/2025*

Implemented (█ - 12/02/2025)

88a - Surfaces

4. 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 7/21/25 at 11:18 AM, the emergency exit door near bedroom #302 did not securely close into the doorframe and had to be physically pushed shut.

On 7/21/25 at 11:25 AM, the emergency exit door near bedroom #320 did not securely close into the doorframe and had to be physically pushed shut.

On 7/21/25 at 11:59 AM, the left door of the double emergency exit doors in the home's main dining room did not securely close into the doorframe and had to be physically pushed shut.

Plan of Correction ***Directed (█ - 09/02/2025)***

All emergency doors were repaired by the Environmental Services Director by July 23rd, 2025. Doors are checked per state requirements. Due to the extreme heat and humidity the doors had swelled.

All exit doors will be checked during established rounds and per regulatory requirements. Doors that require repair will be done by the Environmental Services Department Immediately.

Compliance will be assured with use of rounds checklist that is to be completed by ED/MOD or designee daily x 1 mth then weekly beginning 7/29/25. (DIRECTED: The entire home shall be checked during each round to ensure compliance with 2600.88a. █ 9/2/25

DIRECTED: By 9/25/25: The administrator shall re-educate all staff persons that all floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards. The education shall also include the home's reporting procedures for items that are in need of being repaired or replaced. Documentation of the staff education shall be kept in accordance with 2600.65i. █ 9/2/25

88a - Surfaces (continued)

Compliance to be included in monthly QI meetings by 8/29/25 See attached under 3c

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *09/25/2025*

Implemented █ - 12/02/2025)

101j7 - Lighting/Operable Lamp

5. 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 7/21/25 at approximately 11:30 AM, resident #3's bedside lamp was unplugged and inoperable. No other source of lighting was present that could be turned on/off at resident #3's bedside.

Plan of Correction ***Directed █ - 09/02/2025)***

Lamp was immediately plugged in. Lamp can be turned on and off by switch as you enter the room. Switch was off, lamp was not broken.

Resident educated on light switch and its use with the lamp. Small signs were put near switch and lamp to remind resident on 7/25/25.

All resident rooms were checked beginning 7/23/25 rounds to be done daily x 1 month then weekly by ED/designee (see attachment under 3c) (DIRECTED: Beginning on 9/5/25: The administrator/designee shall check at least 8 different resident bedrooms each month to ensure compliance with 2600.101j7. █ 9/2/25).

Compliance to be included in monthly QI meetings by 8/29/25 See attached under 3c

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *09/05/2025*

Implemented (█ - 12/02/2025)

103f - Refrigerator/Freezer Temps

6. Requirements

2600.

103f - Refrigerator/Freezer Temps *(continued)*

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 7/21/25 at 10:40 AM, the temperature in the secured dementia care unit (SDCU) kitchen refrigerator was 45 degrees Fahrenheit, and at 3:55 PM, it was 43 degrees Fahrenheit.

REPEAT VIOLATION: 4/17/2024, et. al.

Plan of Correction ***Directed [redacted] - 09/02/2025)***

New refrigerator was ordered and current one will not be used for any resident items. Resident drinks will be kept in main kitchen refrigerators until new one is installed.

Compliance will be assured with use of rounds checklist that is to be completed by ED/MOD or designee daily x 1 mth then weekly beginning 7/29/25. (DIRECTED: Beginning on 9/5/25: The Dietary Manager/designee shall inspect all refrigerators/freezers daily for 1 month then weekly thereafter to ensure operable thermometers are present and proper food handling temperatures are maintained in accordance with 2600.103f. Documentation of the audits, which includes temperatures of each refrigerator/freezer, shall be kept for 2 months. [redacted] 9/2/25

DIRECTED: By 9/25/25: The administrator shall re-educate all direct care staff persons and all dietary staff persons on proper food handling temperatures in accordance with 2600.103f. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/2/25

Compliance to be included in monthly QI meetings. See attached under 3c

New refrigerator to be installed 8/30/25 will send work order completion after work is confirmed

Proposed Overall Completion Date: 08/30/2025

Directed Completion Date: *09/25/2025*

Implemented [redacted] - 12/02/2025)

162c - Menus Posted

7. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

162c - Menus Posted *(continued)*

Description of Violation

On 7/21/25, the home's menus posted in conspicuous and public places ended on 7/26/25.

Plan of Correction ***Directed ███ - 09/02/2025)***

Menu is changed Monday morning. Front desk concierge had this in her hand to be changed when it was checked.
Menu was immediately updated

DIRECTED: By 9/10/25: The administrator shall re-educate all staff persons responsible for posting the home's menus to ensure compliance with 2600.162c. Documentation of the education shall be kept.███ 9/2/25

Compliance will be assured with use of rounds checklist that is to be completed by ED/MOD or designee daily x 1 mth then weekly beginning 7/29/25. (DIRECTED: Beginning on 9/9/25: The administrator/designee shall inspect the home at least weekly to ensure compliance with 2600.162c. ███ 9/2/25)

Compliance to be included in monthly QI meetings. See attached under 3c

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *09/10/2025*

Implemented ███ - 12/02/2025)

251c - Standardized Forms

8. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident #3's preadmission screening form, dated ███/25, is not completed on the Department's current preadmission screening form.

Resident #4's preadmission screening form, dated ███/25, is not completed on the Department's current preadmission screening form.

Plan of Correction ***Directed ███ - 09/02/2025)***

The new preadmission screen was immediately done for the above residents.
DOW and MC reviewed all charts for compliance and no additional deficiencies found on 7/25/25

DOW and MC were re-educated by ED on 7/25/25 on use of new pre-admission screening (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. ███ 9/2/25).

All new residents will have chart review by ED or designee within 3 days of admission beginning 7/25/25.

251c - Standardized Forms (continued)

Compliance to be monitored using Preadmission Audit and reviewed at monthly QI meeting beginning July 31th, 2025

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *09/02/2025*

Implemented [redacted] - 12/02/2025)

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

Facility Information

Name: *JUNIPER VILLAGE AT MONROEVILLE* **License #**: *45263* **License Expiration**: *10/18/2025*

Address: *2589 MOSSIDE BOULEVARD, MONROEVILLE, PA 15146*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name:

Legal Entity

Name: *JUNIPER VILLAGE AT MONROEVILLE LLC*
Address: *2589 MOSSIDE BOULEVARD, MONROEVILLE, PA, 15146*
Phone:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *105* **Waking Staff**: *79*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *09/10/2025*

Inspection Dates and Department Representative

08/28/2025 - On-Site:
09/10/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *126* **Residents Served**: *69*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st Floor, Wellsprings* **Capacity**: *21* **Residents Served**: *15*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *69*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *36* **Have Physical Disability**: *1*

Inspections / Reviews

08/28/2025 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/09/2025*

10/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/10/2025*
Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/20/2025*

10/21/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/10/2025*
Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/10/2025*

12/02/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *11/10/2025*
Reviewer: [redacted] **Follow-Up Type**: *Exception*

16c - Written Incident Report

1. Requirements

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

Description of Violation

On 8/7/25, it was reported to staff person A, [redacted] that a medication card containing 30 half tablets of Oxycodone-5mg tablets belonging to resident #1 were missing from the medication cart located on the Wellsprings unit; however, this incident was not reported to the Department.

REPEAT VIOLATION: 2/7/2025; 1/22/2025

Plan of Correction ***Directed ([redacted] - 10/21/2025)***

This Plan of Correction is submitted in accordance with state and federal regulatory requirements. Submission of the POC does not constitute an admission that the deficiencies cited are accurate, that the facts alleged occurred as stated, or that the community agrees with the survey findings. The POC represents the community's commitment to compliance and quality improvement, and any actions described are undertaken to promote resident safety and regulatory compliance, not as an admission of fault or liability.

Incident was reported to state within the regulatory guidelines on August 9th, 2025. See Attached email confirmation and verification. (Exhibit A)

DOW/MC will review incidents and staff communications for reported resident concerns or medication related irregularities daily. (DIRECTED: The daily reviews shall include a review of all incidents specified in 2600.16a to ensure timely reporting to the Department in accordance with 2600.16c. [redacted] 10/21/25). Findings will be discussed daily at stand-up. Reportable incidents will be completed within regulatory guidelines by DOW/designee. During weekend hours, DOW/ED/designee will remotely review staff communications. Findings to be discussed daily at stand-up with follow-up as needed. Log reporting any concerns needing to be addressed will be kept by ED/DOW ongoing. Incident review and log started on 9/11/25 and will be maintained ongoing. (See attached evidence of compliance)

Staff was educated on reportable events: what to report, who to report to, and when to report. The education was completed by ED on Sept 23rd, 2025. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 10/21/25). New staff will be educated upon hire. Staff to receive education on reportable events quarterly by ED/DOW/designee (see attached evidence of compliance) Exhibit B

ED to review reportable event log monthly at QA meeting beginning Sept 25th, 2025 and ongoing the last Thursday of every month. (DIRECTD: Documentation of the quality management reviews shall be kept. [redacted] 10/21/25). (See attached evidence of compliance) Exhibit C

Proposed Overall Completion Date: 10/20/2025

Directed Completion Date: *10/21/2025*

Implemented ([redacted] - 12/02/2025)

185a - Implement Storage Procedures

2. 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 #2 is currently prescribed Tramadol HCL 50mg tablet-Take 1 tablet by mouth every 6 hours as needed. On 8/28/25, 5 tablets of resident #2's Tramadol were present in the home; however, the home's electronic narcotic inventory log indicated 4 tablets of resident #2's Tramadol were present.

Resident #1 is prescribed Oxycodone-5mg tablet-Take 1/2 tablet (2.5mg) by mouth every 4 hours as needed. On 7/18/25, 30 doses of Oxycodone-2.5mg tablets were delivered to the home for resident #1. On 8/7/25, it was discovered that resident #1's Oxycodone and the control drug record were not present in the home. According to resident #1's July 2025 and August 2025 medication administration records (MAR), resident #1 was only administered a dose of the Oxycodone on 7/31/25 and on 8/1/25.

According to the home's "Controlled Substances" policy, "Access to medication storage areas is limited to RN's, LPN's and MA's". According to staff person A, [redacted] r, as well as numerous other staff persons, on 8/8/25, staff person A accessed the medication cart located in the Wellsprings unit and removed a medication card containing as many as 56 half tablets of Oxycodone-5mg tablets belonging to resident #1; however, staff person A is not a RN, LPN, or MA.

According to the home's "Disposal of Medications" policy, "The disposal of medication will be witnessed by two approved associates....The Community will maintain a record of medications that have been destroyed (see Medication Disposal and Release Form)....the Community will maintain records regarding medication destruction on file for three years or per state guidelines for record retention". On 8/8/25, staff person A, [redacted] r, reported [redacted] disposed of as many as 56 half tablets of Oxycodone-5mg tablets belonging to resident #1 while staff person B witnessed the disposal via Facetime; however, staff person B indicated [redacted] was unable to view the actual destruction of the Oxycodone tablets during the facetime call. Staff person B was not physically present in the home during the disposal of medication. Additionally, the correlating control drug record and the medication disposal and release form were not present at the time of inspection.

REPEAT VIOLATION: 1/22/2025; 1/9/2025, et. al.

Plan of Correction ***Directed [redacted] - 10/21/2025)***

In August 2025, facility medication administration system has been upgraded to a pharmacy connect system through PointClickCare (PCC). This system focuses on an electronic trackable exchange related to medication administration and has electronic inventory management. This provides available tracking of controlled substances from ordering to arrival, dispensing, inventory reduction and disposal as needed. This investment of over $25,000 in such a software platform represents an additional measure of compliance support for this facility and it's staff.

The Executive Director (ED) was removed from all medication administration monitoring, facilitation or other medication related matters including access to any/all carts and identified storage areas. Note in the event of a physical plant emergency the ED may be required to enter these areas for the purpose of evacuation compliance

185a - Implement Storage Procedures (continued)

only. The Executive Director was formally counseled on the matter on 10/16/25.

On 10/20/25, an Executive Director [redacted] [redacted] was appointed to be present in the community full-time with the current Executive Director for monitoring and support purposes.. It is noted the community has demonstrated regulatory compliance and that this is an additional support to address and provide consistency and oversight. This [redacted] will continue for at least thirty (30) and may be renewed as needed and reports directly to the Regional Director of Operations to report any variance or concern related to current ED compliance and corrective action as needed.

Effective 10/13/25 The facility has engaged a consultant for compliance review purposes weekly and/or bi-weekly to address and audit regulatory compliance both specific to plan(s) of correction and general overall facility compliance.

Resident # 2 Tramadol.
On August 26th, Juniper had converted the narcotic management to an electronic system.

The routine dose supply was exhausted on 8/26/25. The PRN dose was utilized for the straight order of the medication as well as the PRN. Straight order supply delivered on hand as of 8/28/25

At the time of the survey, medication destruction logs were maintained electronically within Point Click Care. The records are securely stored in this platform, which serves as the centralized repository for medication documentation, including destruction records.

During the survey process, the Executive Director did not access or present these electronic records at the time of review. The record was not provided at the time of surveys due to internal miscommunication between ED and MC. It was believed the MC was providing as they were being interviewed. Following the survey, the community confirmed the location and accessibility of the electronic logs and has ensured that leadership and designated staff are now fully aware of how to retrieve and produce these records promptly upon request The record in question is provided here - Evidence is attached - Exhibit E-

1. Medical Concierge is a Practicum Observer and completed med tech observations med techs which was were completed by Sept 25th, 2025.

Med tech tech observations will be done quarterly for one year with currently trained med techs then annually. New med techs will receive quarterly observations for one year after hired then annually. (DIRECTED: The quarterly med tech observations shall begin on 11/1/25 and be completed by a Department-approved train-the-trainer or Department-approved practicum observer. Documentation of the observations shall be kept. [redacted] 10/21/25).

Monitoring will be completed by MC or designee. Compliance will be monitored monthly by ED/DOW and documented.

ED/designee will review compliance monthly as part of quality assurance. (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 10/21/25).

185a - Implement Storage Procedures (continued)

2. Med techs were educated on Storage procedures/reportable incidents/medication destruction/controlled substances completed on 9/11/25. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. ██ 10/21/25). Education is repeated at least annually as part of competency education process or as needed. New hires will receive education upon hire and prior to working independently as a med tech. (see attached verification of compliance) Exhibit D

Med carts will be audited beginning September 11th, 2025 for 3 months then 3x/week by DOW/MC. (See attached 185a - Implement Storage Procedures (continued) verification of compliance Exhibit F)

DIRECTED: Beginning on 10/27/25: The Medical Concierge/Executive Director Proctor shall review the controlled substances for all residents daily for 1 week, then weekly for 4 weeks, then monthly thereafter. The reviews shall include counting all controlled substances and comparing them to the home's electronic narcotic inventory logs to ensure accuracy. The reviews shall also include reviewing each resident's MAR and comparing them to the electronic inventory logs to ensure accurate and complete medication administration documentation is present in accordance with 2600.185a, as well as in accordance with the home's current policies and procedures. The reviews shall also include reviewing documentation for any controlled substances that were destroyed or removed from the home to ensure accuracy and completeness in accordance with the home's policies and procedures. Documentation of the audits shall be kept for 2 months. ██ 10/21/25

Monitoring and compliance will be completed by MC or designee. (see attached verification of compliance)
ED or designee will review compliance monthly as part of quality assurance.
Resident #1 Oxycodone. ED, on August 7th, 2025 received a call from Medical Concierge (MC) stating that there may be a missing card of narcotics. On August 8th the ED started and internal investigation to determine if a card was missing.

Resident admitted ██/25 and had on card from Alixa RX of Oxycodone 2.5 mg PO q 4 hours. The card had 52 pills of Oxycodone.

Forest Hills Pharmacy delivered one card of 15 Oxycodone on 7/18/25 and another card on of 15 oxycodone on 8/7/25.

On 8/7/25 when card was delivered resident should have had now 3 cards on hand. The med tech stated there were only 2 cards. One from the outside pharmacy ██

On August 8th the ED audited the narcotics drawers on all 3 units as a protective oversight measure.

ED did the audit on the 2nd and 3rd floor with the med tech on duty. The 1st floor, was directly after 2nd and 3rd floors.)

After further investigation on August 9th and 10th, pharmacy confirmed that facility should be 2 cards from ██ ██ delivered on 7/18/25 and 8/7/25. Community confirmed on 8/9/25 that a card of 15 Oxycodone, the delivery sheet and the narcotic record were all missing.

185a - Implement Storage Procedures (continued)

The ED was providing protective oversight to address and reduce potential adverse medication administration variance, med error or other occurrence in the absence of the Director of Wellness (DOW). It was believed by the ED that the presence of an additional external card of narcotics could be problematic or create an error or other risk of adverse outcome. The ED removed the outside card for destruction of 52 half tabs of oxycodone. This was witnessed by the med tech and documented as required. The medications were then destroyed in the med buster solution. As this is a policy variance undertaken for the protective oversight of resident care and services, the ED utilized a secondary witness measure (remote face-time with a manager) as an overabundance of caution and verification. The med tech witnessed the event as well as the MC (via iphone FaceTime) whom ED called to have a 3rd party verification. The med tech stated ▮ was unaware of the card count form and has never used it and ▮ had asked the ED if we had a storage space for narcotics not stored in cart. ED educated that narcotics are not stored outside of the narcotic drawer as this would "need to be in a secure locked area like a safe." ED explained that the community does not have a safe available or any double-locked and monitored area for narcotics other than the med cart. Med Tech witness signed off on narcotic record. (- Exhibit F -) Included in Exhibit A

ED completed narcotic cart audit between 230pm and 330pm in the SDU. 2nd and 3rd floors had already been completed.

ED followed and adhered to the disposal of medication policy and has intermittently in the past done spot check audits for expired med/proper labeling/prn documentation and always witnessed by a med tech.

This incident was reported within 24 hours (see attached verification of compliance – Exhibit G -)
Included in Exhibit A
I

Proposed Overall Completion Date: 10/20/2025

Directed Completion Date: *11/10/2025*

Implemented ▮ - 12/02/2025)

225a - Assessment 15 Days

3. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #3's medical evaluation, dated ▮/25, includes diagnoses of Hemorrhoids, Lupus and Hypokalemia; however, these diagnoses were not indicated on resident #3's assessment, dated ▮/25.

REPEAT VIOLATION: 2/7/2025

Plan of Correction ***Directed ▮ - 10/21/2025)***

225a - Assessment 15 Days (continued)

Medical support plan was reviewed by consultant on October 15th 2025. The support plan on 1/7/25 and1/13/25 as well as the DME show no evidence of diagnoses of Hemorrhoids, Lupus, and Hypokalemia.

It is noted this information was not listed anywhere in the medical support plan.

DOW has added these diagnoses to the Medical Support Plan.

Resident support plans were audited and completed on /2025 (see attached verification of compliance with chart audit).

Resident support plans are currently being audited by Juniper consultants with completion date of /25

New resident support plans will be reviewed within 48 hours of admission starting September 11th 2025 by ED or designee (see attached Support Plan audit for verification of compliance).

ED re-educated DOW and MC on timely submission of support plans on September 11th, 2025. (see attached Exhibit I)) (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 10/21/25

Chart audits and compliance with support plan and verification of compliance will be reviewed at monthly QA meeting by ED/designee beginning the 4th Thursday in September and ongoing monthly. (See attached QA minutes on Sept 25th for verification of compliance) (DIRECTED: Documentation of the quality management reviews shall be kept. 10/21/25).

Proposed Overall Completion Date: 10/20/2025

Directed Completion Date: *10/22/2025*

Implemented 02/2025)

234a - Admission Support Plan

4. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

234a - Admission Support Plan *(continued)*

Description of Violation

Resident #1 was admitted to the home's secured dementia care unit (SDCU) on [redacted]/25; however, resident #1's initial support plan was not completed until [redacted]5.

Plan of Correction ***Directed [redacted] - 10/21/2025)***

Resident support plans were audited by DOW and MC and completed on [redacted]3/2025 (see attached chart audit for verification of compliance Exhibit J).

Resident support plans are to be audited by Juniper consultants with completion date of 10/22/25 and documentation of compliance will be available and reviewed by ED.

New resident support plans will be reviewed within 48 hours of admission starting September 11th 2025 by ED or designee (Exhibit J- Support Plan audit for evidence of compliance).

ED re-educated DOW and MC on timely submission of support plans on September 11th, 2025 (see attached evidence of compliance) (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted]/21/25).

Chart audits and compliance with support plan completion will be reviewed as part of monthly quality assurance by ED beginning on or about the 4th Thursday in September and ongoing monthly. (See attached QA minutes on Sept 25th for evidence of compliance) (DIRECTED: Documentation of the quality management reviews shall be kept. [redacted] 10/21/25).

Proposed Overall Completion Date: 10/20/2025

Directed Completion Date: *10/22/2025*

Implemented [redacted] - 12/02/2025)