





# Pennsylvania Department of Human Services

Emailing Date: November 13, 2025

[REDACTED]  
Mechanicsburg Senior Care LLC  
[REDACTED]

RE: Vibra Senior Living  
707 Shepherdstown Road  
Mechanicsburg, Pennsylvania 17055  
License/COC #: 331091

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on July 24, 2025, July 25, 2025, September 24, 2025 and September 25, 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,

A handwritten signature in black ink that reads "Juliet Marsala".

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 - PUBLIC

November 12, 2025

[REDACTED]  
MECHANICSBURG SENIOR CARE LLC  
[REDACTED]  
[REDACTED]

RE: VIBRA SENIOR LIVING  
707 SHEPHARDSTOWN ROAD  
MECHANICSBURG, PA, 17055  
LICENSE/COC#: 33109

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/24/2025, 09/25/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,  
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: VIBRA SENIOR LIVING License #: 33109 License Expiration: 10/23/2025
Address: 707 SHEPHARDSTOWN ROAD, MECHANICSBURG, PA 17055
County: CUMBERLAND Region: CENTRAL

Administrator

Name: [Redacted]

Legal Entity

Name: MECHANICSBURG SENIOR CARE LLC
Address: [Redacted]

Certificate(s) of Occupancy

Type: I-2 Date: 12/12/2013 Issued By: Upper Allen Township

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 55 Waking Staff: 41

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Complaint, Interim Exit Conference Date: 09/25/2025

Inspection Dates and Department Representative

09/24/2025 - On-Site: [Redacted]
09/25/2025 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 46 Residents Served: 35

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 3

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 35
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 20 Have Physical Disability: 1

Inspections / Reviews

09/24/2025 - Partial

Lead Inspector: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 10/26/2025

10/27/2025 - POC Submission

Submitted By: [Redacted] Date Submitted: 11/07/2025
Reviewer: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 10/31/2025

Inspections / Reviews *(continued)*

10/29/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/07/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 11/07/2025

11/12/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/07/2025

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

65d - Initial Direct Care Training

1. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

- 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Staff member A, hired on [redacted] 25, began providing unsupervised ADL services on 9/21/25. However, the staff member did not complete and pass the Department-approved direct care training course and pass the competency test.

Repeated Violation - 3/19/25, et al.

Plan of Correction

Accept [redacted] - 10/29/2025)

65D – Initial Direct Care Training

2600.65.d

- Staff Person A completed the Director Care Staff Training and Competency Test on [redacted]/2025.
- Education given to HR Director on [redacted] 0/25 stating that Direct Care Staff may not provide unsupervised ADL services until completion of the Direct Care Training Course and passing of the competency test; going forward, all Direct Care Staff must have their DCT prior to starting on the floor for orientation; HR Director will ensure that all direct care staff have DCT's in their employee files.
- Direct Care Staff Certificate Audit completed on all employees by HR Director on [redacted]/2025.
- Effective immediately all new hires that do not have the Direct Care Training certificate will be scheduled/set up for this training by HR and/or PCHA on their first day of orientation to complete this training prior to starting on the floor. Staff will not work the floor unit training is complete and certificate is presented.
- HR Director will conduct audit 2x a month for 4 months on all new hires to ensure that all staff have DCT certificate and passing of the competency test in their HR file beginning on 11/1/2025.

Licensee's Proposed Overall Completion Date: 11/01/2025

Implemented [redacted] - 11/12/2025)

89b - Hot Water Temperature

2. Requirements

2600.

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

Description of Violation

On 9/25/25 at 10:20 AM, the hot water temperature in the bathroom sink of resident room #700 measured 123.0 degrees Fahrenheit. The hot water temperature in the shower measured 122.2 degrees Fahrenheit.

Plan of Correction

Accept [redacted] - 10/29/2025)

2600.89.b – Hot Water Temperature

2600.89.b

- Home is unable to retroactively correct this violation on 9/25/25.
- Maintenance Director adjusted water temp in [redacted] on 9/25/25 and received a reading of 117 degrees.
- Maintenance Director completed an initial audit on all showers/sinks in resident's room on 10/22/25.
- Education provided by PCHA on 10/20/25 to Maintenance Director on Hot Water temperatures in all areas accessible to the residents that may not exceed 120 degrees and to hold thermometer under water for at least 2

**89b - Hot Water Temperature (continued)**

minutes to get an accurate reading of temperature going forward.

- Audits to be completed starting week of 11/1/25 by Maintenance Director on all rooms 1x a week for 4 weeks and then all rooms 2x a month for 2 months.

Licensee's Proposed Overall Completion Date: 11/01/2025

Implemented [REDACTED] - 11/12/2025)

**141b2 - Medical Evaluation Changes****3. Requirements**

2600.

141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

**Description of Violation**

Resident #1's medical evaluation, dated [REDACTED] 25, indicated that the resident had minimal mobility needs, requiring limited physical or oral assistance to evacuate in an emergency. However, Resident #1's assessment, dated [REDACTED]/25, was updated on 9/16/25 to include the resident's need for a two person assist for transfers in the evening and early morning hours. Resident #1 did not have a medical evaluation completed to reflect the resident's change in mobility needs.

**Plan of Correction**

Accept [REDACTED] - 10/27/2025)

141.b.2 – Medical Evaluation Changes

2600.141b2

- Medical evaluation completed and faxed to physician to complete on [REDACTED]/2025 for Resident #1.
- Initial audit completed by PCHA on 10/19/2025 for all resident's to ensure all DME's are accurate and updated to reflect current medical and/or functional status of resident.
- Education provided on 10/20/25 to PCHA and RCC by Executive Director to ensure all residents have updated and accurate DME's to reflect current medical/functional needs.

141b2 - Medical Evaluation Changes (continued)

- Starting the week of 11/3/25, audits to be conducted by PCHA/RCC to ensure DME's reflect current medical/functional needs. Audits will be conducted 1x a month for 6 months on 10 residents each month.

Licensee's Proposed Overall Completion Date: 11/03/2025

Implemented [REDACTED] - 11/12/2025)

183b - Meds and Syringes Locked

4. 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 9/25/25 at 10:10 AM, a bottle of Proclearz anti-fungal shield was unlocked, unattended, and accessible in Resident #5's bedroom. Resident #5 is not assessed to self-administer medications.

On 9/25/25 at 10:20 AM, a container of Nystop powder was unlocked, unattended, and accessible in Resident #6's bedroom. Resident #6 is not assessed to self-administer medications.

Repeated Violation - 3/19/25, et al.

Plan of Correction

Accept [REDACTED] - 10/27/2025)

183B – Meds and Syringes Locked

2600.183.b

- Home is unable to retroactively correct this violation.
- PCHA immediately removed the bottle of Proclearz anti-fungal shield from Resident# 5's room and the Nystop powder from Resident# 6's room.
- Initial audit completed on 10/22/2025 by PCHA/RCC on all resident room's to ensure that there were no prescription medications, OTC medications, CAM and/or syringes in any resident room.
- Education given to RCC and Medication Technicians by PCHA on 10/20/2025 and 10/21/2025 addressing that all prescription medications, OTC medications, CAM and/or syringes are to be kept in an area or container that is locked.
- Beginning the week of 11/1/25 audits will be completed by PCHA and/or designee 2x a month for 6 months on 5 residents to ensure there are no prescription medications, OTC medications, CAM and/or syringes in resident rooms.

Licensee's Proposed Overall Completion Date: 11/01/2025

Implemented [REDACTED] - 11/12/2025)

183d - Prescription Current

5. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

183d - Prescription Current (*continued*)**Description of Violation**

On 9/25/25 at 10:20 AM, a container of Nystop powder prescribed for Resident #6 was in the resident's bathroom; however, the medication was discontinued on 8/27/25.

**Plan of Correction**

Accept [REDACTED] - 10/29/2025)

183D – Prescription Current

2600.183.d

- Home is unable to retroactively correct this violation.
- On 9/25/25, PCHA immediately removed the bottle of Nystop powder from Resident# 6's room.
- Initial audit completed on 10/22/2025 by PCHA/RCC on all resident room's to ensure that there were no prescription medications, OTC medications, CAM and/or syringes in any resident room.
- Initial audit to be completed by RCC by 11/7/25 to ensure each medication has a current order and no discontinued medications are in the home.
- Education given to RCC and Medication Technicians by PCHA on 10/20/2025 and 10/21/2025 addressing that all prescription medications, OTC medications, CAM and/or syringes are to be kept in an area or container that is locked and that all medications must have a current valid order before administering medication.
- Beginning the week of 11/1/25 audits will be completed by PCHA and/or designee 2x a month for 6 months on 5 residents to ensure that all treatments have a valid current order.

Licensee's Proposed Overall Completion Date: 11/07/2025

Implemented [REDACTED] - 11/12/2025)

## 183e - Storing Medications

**6. 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.

**Description of Violation**

On 9/25/25, Preparation H suppositories prescribed for Resident #7 were in the home's medication cart; however, the medication expired 06/2025.

Repeated Violation - 1/7/25, et al.

**Plan of Correction**

Accept [REDACTED] - 10/29/2025)

83E – Storing Medications

2600.183.e

- Home is unable to retroactively correct this violation.
- On 9/25/25, RCC immediately removed the Preparation H suppositories prescribed for Resident# 7 from the medication cart.
- RCC spoke with [REDACTED] on 9/25/25 requesting that he provide new preparation H suppositories. Son received an order from the DR on 10/1/25 discontinuing preparation H suppositories.

183e - Storing Medications (continued)

- Initial audit completed on 10/15/2025 by RCC for the 500/600/700 medication carts to ensure all medications are current and that no medications were expired.
- Education given to RCC and Medication Technicians by PCHA on 10/22/2025 for making sure that all medications given to a resident are current and non-expired.
- Carts will be audited by RCC 2x a month to ensure all medications are current and that there are no expired medications. If medications are close to expiration, RCC will reach out to families or pharmacy to have medications delivered with current expiration dates. **(Directed) The audits being conducted by the RCC will begin the week of 11/1/25**.
- Beginning the week of 11/1/25 audits will be completed by PCHA and/or designee 2x a month for 6 months on 5 residents to ensure that all treatments and medications have a current expiration date.

Licensee's Proposed Overall Completion Date: 11/01/2025

Implemented - 11/12/2025)

184a - Resident's Meds Labeled

7. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The bottle of Nystop powder, prescribed for Resident #6 was not labeled with a pharmacy label to include: the resident's name, the name of the medication, the prescribed dosage and instructions for administration, the name and title of the prescriber.

Plan of Correction

Accept - 10/29/2025)

184a – Resident's Meds Labeled

2600.184.a

- Home is unable to retroactively correct this violation.
- On 9/25/25, PCHA immediately removed the bottle of Nystop powder from Resident# 6's room.
- Nystop powder was discontinued when Resident #1 returned from Rehab on 8/25/25.
- Initial audit completed on 10/15/2025 by RCC for the 500/600/700 medication carts to ensure all medications and treatments are labeled with resident's name, name of medication, prescribed dosages/instructions for administration and name/title of prescriber.
- Education given to RCC and Medication Technicians by PCHA on 10/22/2025 for making all medications and treatments are labeled with resident's name, name of medication, prescribed dosages/instructions for administration and name/title of prescriber.
- Carts will be audited by RCC 2x a month to ensure all medications and treatments are labeled with resident's name, name of medication, prescribed dosages/instructions for administration and name/title of prescriber. **(Directed) The audits being conducted by the RCC will begin the week of 11/1/25**.
- Beginning the week of 11/1/25 audits will be completed by PCHA and/or designee 2x a month for 6 months on 5

**184a - Resident's Meds Labeled (continued)**

*residents to ensure all medications and treatments are labeled with resident's name, name of medication, prescribed dosages/instructions for administration and name/title of prescriber.*

Licensee's Proposed Overall Completion Date: 11/01/2025

Implemented (█ - 11/12/2025)

**225c - Additional Assessment**

**8. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

- 2. If the condition of the resident significantly changes prior to the annual assessment.

**Description of Violation**

*Resident #10's assessment, dated █/24, indicated 1-2 staff members to assist with transferring from bed/chair and chair/bed, total assistance of 1 staff member for toileting, bladder and bowel management, and requires one staff member to assist to wheelchair and to evacuate in the event of an emergency. However, Resident #10 has required the assistance of at least 2 staff members for toileting and transfers and required the assistance of 3 staff to assist from the floor on 6/27/25. The resident's assessment has not been updated to reflect the resident's changes in needs.*

**Plan of Correction**

Accept (█ - 10/27/2025)

2600.225.c – Additional Assessment

2600.225c

- PCHA updated support plan and DME on 10/24/205 to reflect the resident's changes in need on Resident #10
- Education provided by Executive Director to PCHA and RCC on 10/24/25 to ensure all support plans are updated with changes on all resident's.
- Initial audit of resident support plans will be conducted by RCC/PCHA to be completed by 10/24/25.
- Starting the week of 11/3/25, audits will be conducted by PCHA/RCC; 2x a month for 4 months on 5 residents to ensure support plan matches resident care needs.

Licensee's Proposed Overall Completion Date: 11/03/2025

Implemented (█ - 11/12/2025)

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

November 12, 2025

[REDACTED]  
MECHANICSBURG SENIOR CARE LLC  
[REDACTED]  
[REDACTED]

RE: VIBRA SENIOR LIVING  
707 SHEPHARDSTOWN ROAD  
MECHANICSBURG, PA, 17055  
LICENSE/COC#: 33109

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/24/2025, 07/25/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: *VIBRA SENIOR LIVING* License #: *33109* License Expiration: *10/23/2025*  
 Address: *707 SHEPHARDSTOWN ROAD, MECHANICSBURG, PA 17055*  
 County: *CUMBERLAND* Region: *CENTRAL*

**Administrator**

Name: [REDACTED]

**Legal Entity**

Name: *MECHANICSBURG SENIOR CARE LLC*  
 Address: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-2* Date: *12/12/2013* Issued By: *Upper Allen Township*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *57* Waking Staff: *43*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Provisional* Exit Conference Date: *07/25/2025*

**Inspection Dates and Department Representative**

07/24/2025 - On-Site: [REDACTED]  
 07/25/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *46* Residents Served: *34*

**Secured Dementia Care Unit**

In Home: *No* Area: Capacity: Residents Served:

**Hospice**

Current Residents: *4*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *34*  
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *23* Have Physical Disability: *1*

**Inspections / Reviews**

**07/24/2025 - 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: *09/07/2025*  
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/29/2025*

Inspections / Reviews *(continued)*

08/27/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/07/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 09/08/2025

11/12/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/07/2025

Reviewer: [REDACTED]

Follow-Up Type: Not Required

## 15a - Resident Abuse Report

### 1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

### Description of Violation

On [REDACTED] 25 at 10:45 AM, an alleged incident of resident abuse from a resident's [REDACTED] was reported to the Resident Care Coordinator and Personal Care Director. The allegation of abuse was not reported to the Area Agency on Aging in accordance with the Older Adult Protective Services Act.

On 7/12/25, the home's Executive Director was informed of suspected financial abuse for residents #1 and #2; however, the allegation of abuse was not reported to the Area Agency on Aging in accordance with the Older Adult Protective Services Act.

Repeated Violation - 1/7/25 et al

### Plan of Correction

Accepted [REDACTED] - 08/27/2025)

15a – Resident Abuse Report

2600.15.a

Home is unable to retroactively correct this violation for incident on 2/23/25.

Act 13 Form completed by PCHA on 8/13/2025 for Residents #1 and #2 and reported to AAA for incident on 7/12/25.

Act 13 form completed on 8/27/25 by PCHA for Resident 3 and faxed to AAA for incident on 2/22/25.

RCC and Executive Director educated by PCHA on 8/13/2025 to accurately report allegations, financial abuse and/or injuries in a timely manner to AAA.

PCHA to educate staff on forms of abuse and mandated reporting and completed by 9/4/25.

Initial audit completed on 8/13/25 for all reportables completed from May 2025 until current, to ensure all reportables were reported to appropriate agencies.

Starting 8/25/25 weekly audits to be conducted on current submitted reportables and progress notes for timely submission of reportables. Audits to be completed 1x a week for 12 weeks by PCHA/designee on 5 residents.

Licensee's Proposed Overall Completion Date: 09/04/2025

Implemented [REDACTED] - 11/12/2025)

## 16c - Written Incident Report

### 2. Requirements

2600.

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

### Description of Violation

On 2/23/25 at 10:45 AM, the [REDACTED] of resident #3 was yelling at the resident and forcefully getting the resident out of bed. After the resident had eaten and had medication, the [REDACTED] stated that the resident was getting up and continued to the room to tell the resident [REDACTED] needed to get up, yelling at the resident. The Resident Care Coordinator and Personal Care Director confirmed that they were aware of this incident and did not report it to the Department.

## 16c - Written Incident Report (continued)

Repeated Violation - 3/19/25 et al., 1/7/25 et al.

## Plan of Correction

Accept ( ) - 08/27/2025)

16c – Written Incident Report

2600.16.c

Home is unable to retroactively correct this violation.

PCHA submitted reportable to DHS on 8/27/25 for Resident 3 on incident dated /25.

PCHA and RCC educated by Executive Director on 8/13/2025 to accurately report all allegations of abuse in a timely manner.

PCHA to educate staff on forms of abuse and mandated reporting and completed by 9/4/25.

Initial audit completed on 8/13/25 for all reportables completed from May 2025 until current, to ensure all reportables were reported to appropriate agencies.

Starting 8/25/25 weekly audits to be conducted on current submitted reportables and progress notes for timely submission of reportables. Audits to be completed 1x a week for 12 weeks by PCHA/designee on 5 residents.

Licensee's Proposed Overall Completion Date: 09/04/2025

Implemented /12/2025)

## 65a - FS Orientation 1st Day

## 4. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

## Description of Violation

Staff member C, whose first day of work was /25, and staff member D, whose first day of work was /25, did not receive orientation on the following topics:

- (1) Evacuation procedures.
- (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- (3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
- (4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- (5) The location and use of fire extinguishers.
- (6) Smoke detectors and fire alarms.
- (7) Telephone use and notification of emergency services.

65a - FS Orientation 1st Day (continued)

**Plan of Correction**

Directed [REDACTED] - 08/27/2025)

2600.65a. - FS Orientation 1st Day

2600.65.a

FS Orientation education provided to Staff Member D on 8/25/25 by PCHA.

Unable to correct violation for Staff Member C as that agency staff member has not picked up a shift at the facility since [REDACTED]/25. PCHA attempted to reach out to [REDACTED] on 8/26/25 and 8/27/25 with no return response.

HR Director will complete initial audit of all agency staff to be completed by 9/1/25. HR Director will reach out to agency staff to conduct educations by 9/5/25.

Effective 8/21/25 HR director will provide fire safety/facility orientation to all agency staff going forward.

Education provided by PCHA to HR director on regulation 2600.65.a on 8/21/25

Audits to be conducted starting week of 9/8/25 by HR director for 1x week for 4 weeks and then 2x a month for 2 months to ensure agency staff have reviewed and understand FS Orientation; agency staff will sign education form with HR Director/PCHA or RCC.

(Directed)

In addition to the above plan of correction:

- Staff member C will receive education on training topics specified in 2600.65(a) prior to completing any additional shifts in the home.

Directed Completion Date: 09/08/2025

Implemented [REDACTED] - 11/12/2025)

89b - Hot Water Temperature

**5. Requirements**

2600.

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

**Description of Violation**

On 7/25/25 at 10:10 AM, the hot water temperature at the kitchenette sink in bedroom 504 measured 124 degrees Fahrenheit and at 10:18 AM, it was 124.2 degrees Fahrenheit.

On 7/25/25 at 10:40 AM, the hot water temperature at the kitchenette sink in bedroom 604 measured 124.7 degrees Fahrenheit.

On 7/25/25 at 10:30 AM, the hot water temperature at the kitchenette sink in bedroom 704 measured 122.5 degrees Fahrenheit.

**Plan of Correction**

Accept [REDACTED] - 08/27/2025)

2600.89.b – Hot Water Temperature

2600.89.b

Home is unable to retroactively correct this violation on 7/25/25.

Maintenance Director completed initial audit on 8/22/25 on all sinks. All water temperatures were corrected

**89b - Hot Water Temperature (continued)**

*immediately at time of audit by Maintenance Director on 8/22/25.*

*Education provided by PCHA on 8/18/25 to Maintenance Director and staff on Hot Water temperatures in areas accessible to the resident may not exceed 120 degrees and to hold thermometer under water for at least 2 minutes to get an accurate reading of temperature.*

*Audits to be completed starting week of 9/1/25 by Maintenance Director, 2 rooms on each hall 1x a week for 4 weeks and then 2 rooms on each hall bi-weekly for 3 months.*

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

**Implemented (█ - 11/12/2025)**

**91 - Telephone Numbers**

**6. Requirements**

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

**Description of Violation**

*The emergency service numbers in resident bedrooms including rooms 515, 704, and 604 did not include the correct personal care home complaint hotline.*

**Plan of Correction**

**Accept (█ - 08/27/2025)**

*91 – Telephone Numbers*

*2600.91*

*Initial audit completed by PCHA on 8/13/2025 for all rooms and common area phones on personal care. All phone number tags were corrected and updated in all rooms/phones including rooms 515, 604 and 704 by Maintenance Director and PCHA on 8/15/2025.*

*PCHA, RCC and Maintenance Director educated by Executive Director on 8/13/2025 on having emergency telephone numbers available to all residents in their rooms and at all phones in common areas on Personal Care.*

*Starting 9/1/2025 audits to be completed 1x a month for 4 months by PCHA/designee to ensure all rooms/phones have emergency contact numbers available.*

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

**Implemented (█ - 11/12/2025)**

**101o - Walls, Floors, Ceilings**

**7. Requirements**

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

**Description of Violation**

*A hole in the wall, measuring at least 8 inches by 6 inches was located in resident #4's bedroom; the area had peeling paint and areas of exposed drywall.*

**Plan of Correction**

**Accept (█ - 08/27/2025)**

*101o – Walls, Floors, Ceilings*

101o - Walls, Floors, Ceilings (continued)

2600.101.o

Maintenance Director is currently working on correcting this violation.

Wall will be fixed, spackled and painted by EOD 8/30/25.

Maintenance Director educated by PCHA on 8/18/25 that all rooms must be maintained and in good working order.

All walls, floors and ceilings must be finished, clean and in good report.

PCHA will educate personal care on using work orders to report maintenance needs to all maintenance staff starting week of 8/25/25. Education is on-going with all personal care.

Audits to be conducted starting week of 8/25/2025 by Maintenance Director for 10 rooms 1x a week for 4 weeks and then 10 rooms 2x a month for 2 months.

Licensee's Proposed Overall Completion Date: 08/30/2025

Implemented (█ - 11/12/2025)

132d - Evacuation

8. 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

The fire drill held on 4/29/25 at 2:21 AM had an evacuation time of 22 minutes and 31 seconds. The maximum safe evacuation time specified in writing within the past year by a fire safety expert is 6 minutes and 46 seconds.

Plan of Correction

Accept (█ - 08/27/2025)

2600.132.d. – Evacuation

2600.132.d

Unable to correct evacuation time for fire drill on 4/29/25 at 2:21 AM

Subsequent evacuation time for fire drill on 7/31/25 at 06:15am met the time requirement.

Education will be conducted by Maintenance Director on (resident council date) during resident council to reeducate the residents of the need for evacuation drills and the benefits for safety of all residents and staff. **(Directed)**

**Residents will receive education by 9/8/25** (█)

Education for staff regarding planning for residents needing assist to meet the time requirements will be provided by Maintenance Director at PC Staff Meetings on 9/4/25.

Education and ongoing fire drills will be reported to QAPI and subsequently to the governing body.

Effective 9/1/25, Maintenance Director, PCHA, RCC and ED will meet within 24-48 hours of any fire drill exceeding maximum safe evacuation time to discuss any barriers related to the fire drill. Failed fire drills will be repeated within 7 days from original drill.

Audits will be conducted 1x a month for 4 months by Maintenance Director, audits to start 9/1/25.

Licensee's Proposed Overall Completion Date: 09/08/2025

Implemented (█ - 11/12/2025)

## 141b2 - Medical Evaluation Changes

## 9. Requirements

2600.

141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

## Description of Violation

Resident #5's most recent medical evaluation was completed on [REDACTED]/24. Resident #5 started receiving hospice services on [REDACTED]/25 for senile degeneration of the brain and the use of a bedside commode was ordered as well as a hospital bed. On 4/1/25, resident #5's dietary order was changed to pureed diet with thickened liquids due to the resident choking while eating and drinking. A medical evaluation has not been completed with the change in medical condition(s).

## Plan of Correction

Accept [REDACTED] 08/27/2025)

141.b.2 – Medical Evaluation Changes

2600.141b2

Medical evaluation completed and signed by physician on [REDACTED]/2025 for Resident #5.

Initial audit completed by PCHA on 8/18/2025 for all hospice residents for completion for medical evaluation at time of hospice admission.

Medical evaluations updated and completed on 8/18/2025 and 8/19/2025 for all hospice residents.

Education provided on 8/18/25 to PCHA and RCC by Executive Director on Regulation 2600.141.b.2.

Starting week of 9/1/25, audits to be conducted by PCHA/RCC. Audits will be 1x monthly for 6 months to ensure all hospice residents have updated medical evaluations, if applicable.

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

Implemented [REDACTED] - 11/12/2025)

## 162c - Menus Posted

## 10. 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.

## Description of Violation

The home's menus for a five-week period were posted. However, there was no indication as to which menu was the current' week's menu nor which menu was scheduled for the week in advance.

## Plan of Correction

Accept [REDACTED] - 08/27/2025)

2600.162.c. Menus Posted

2600.162.c

Home is unable to retroactively correct this violation.

Dated Weekly menus will be posted in the Lobby by Dietary Manager 1 week in advance of meals served. **(Directed) dated weekly menus will be posted in the lobby 1 week in advance no later than 9/1/25-[REDACTED]**

Daily dated menu will be posted near Personal Care dining Room next to the Activity Calendar.

Dated Weekly menu will be posted near the Personal Care Dining Room

On 8/20/25, education was provided from PCHA to Dietary Manager on Regulation 2600.162.c and having weekly menu's posted for residents and family.

Starting week of 8/25/25, dated weekly menus will be passed out to resident rooms in advance of date served by

162c - Menus Posted (continued)

Dietary Manager.

Starting week of 9/1/25, audits will be conducted by Dietary Manager 2x a week for 4 weeks and then 1x a week for 2 months.

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

Implemented [REDACTED] - 11/12/2025)

184a - Resident's Meds Labeled

11. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- 4. The prescribed dosage and instructions for administration.
- 5. The name and title of the prescriber.

Description of Violation

The Basaglar Kwikpen prescribed for resident #6 did not have a pharmacy label to include the prescribed dosage and instructions for administration or the name and title of the prescriber.

Plan of Correction

Accept [REDACTED] - 08/27/2025)

184a – Resident’s Meds Labeled

2600.184.a

Basaglar Kwikpen last dose used 8/18/2025, new refill pen in fridge with label and moved to cart for use on 8/18/2025. Kwikpen now has original pharmacy label.

Education will be provided to Medication Technicians/Agency Staff by PCHA starting week of 8/25/25 on ensuring all medications/insulin pens that are provided by the pharmacy have a pharmacy label on the medication also ensuring that label has prescribed dosages/instructions for administration and name/title of prescriber. **(Directed) All medication technicians/agency staff will receive education no later than 9/4/25-** [REDACTED]

Education on-going with medication technicians/agency staff.

Initial cart audits to be completed by 8/27/2025 by RCC.

Audits will be conducted 2x a week for 4 weeks and then 1x a week for 8 weeks beginning on week of 9/1/25.

Licensee's Proposed Overall Completion Date: 09/04/2025

Implemented [REDACTED] /12/2025)

185a - Implement Storage Procedures

12. 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 #6 was prescribed Admelog Solostar, inject under the skin three times daily as per sliding scale. On 7/18/25 at 5:00 PM, resident #6's medication administration record documented a blood glucose reading of 183. The reading in the resident's Libre reader on 7/18/25 at 5:27 PM was 182.

185a - Implement Storage Procedures (continued)

The following readings were documented on resident #6's medication administration record but were not found in the resident's Libre reader:

- 7/17/25 12:00 PM – 214
- 7/12/25 12:00 PM – 186
- 7/12/25 5:00 PM – 260
- 7/11/25 8:00 AM - 209
- PRN check 7/8/25 12:00 PM – 108

Repeated Violation 3/19/25, et al., 1/7/25, et al.

Plan of Correction

Accept [REDACTED] - 08/27/2025

185a – Implement Storage Procedures  
2600.185.a

- Unable to correct the incorrect documented blood glucose reading on MAR for Resident 6 on 7/18/2025.
- Home is unable to retroactively correct this violation for missing blood glucose numbers on reader for 7/17 at 12pm, 7/12 at 12pm, 7/12 at 5pm, 7/11 at 8am and 7/8 at 12pm.
- Education will be provided the week of 8/25/25 by PCHA to RCC, Med Techs and Licensed Staff on proper use of blood glucose monitor and documentation on MAR for blood sugar readings. **(Directed) All medication technicians/agency staff will receive education no later than 9/4/25 [REDACTED].** Education will remain ongoing with staff.
- On 8/20/25, RCC and PCHA conducted investigation to determine why readings were not listed on the blood glucose monitor but were listed on the MAR. LPN's from skilled and agency were unaware of the extra step on how to save BS reading on monitor. LPN's assumed that the reading would automatically save on the monitor. Verbal education given to LPN's for monitor and were shown extra steps by RCC on 8/20/25 and 8/21/25.
- Audits to begin the week of 8/25/25 for 2x a week for 4 weeks and then 1x weekly for 8 weeks on MAR and Blood Glucose Monitor for residents who have blood sugar checks to be completed by RCC.

Licensee's Proposed Overall Completion Date: 09/04/2025

Implemented [REDACTED] - 11/12/2025

187a - Medication Record

13. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

3. Name of medication.
5. Dosage form.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #3 had prescribers' orders for Atropine Sulfate Ophthalmic Solution 1%, place 2 drops under the tongue every 4 hours as needed for excessive secretions. The resident's July 2025 Medication Administration Record indicated Atropine 1% eye drops.

**187a - Medication Record (continued)**

Resident #6 was prescribed Admelog Solostar inject under the skin three times daily as per sliding scale: 150-200 = 200U, 201-250 = 4U, 251-300 = 6U, 301-350 = 8U, 351-400 = 10U, call provider if above 400. The resident's July 2025 Medication Administration Record and Master Signature Log did not document the name of the staff who checked the resident's blood glucose level on 7/18/25 at 5PM.

Repeated Violation - 4/1/25, 3/19/25, et al.

**Plan of Correction****Directed (█ - 08/27/2025)****2600.187a – Medication Record**

- Home is unable to correct action for Resident 6 as agency nurse has not returned for additional shifts since that time.
- RCC corrected Resident #3's MAR on 8/1/2025.
- Education given to RCC by PCHA on 8/18/25 on regulation 187a to ensure all prescribers orders are transcribed to MAR/TAR accurately.
- Education provided by PCHA starting week of 8/25/25 on signing master log to all licensed staff.
- RCC will create "to do" binder for all agency staff who pick up shifts at facility, to include signing Master Log during week of 8/25/2025.
- RCC removed master log sheets from NARC and MAR books. RCC now has one master log sheet that is to be signed by all current and new staff upon start of first shift at facility. RCC will place sign in front of 500/600/700 MAR stating "STOP! Prior to starting med pass, please sign master log located in 500 nurse station hanging on the bulletin board." Sign will be placed 8/27/2025 by RCC.
- Beginning week of 8/25/25, audits will be on 10 residents MAR's/TAR's to be audited 1x a week for 12 weeks to ensure all prescribers orders match MAR/TAR's.

(Directed)

In addition to the above plan of correction, beginning no later than 9/1/25, an audit will be completed weekly on at least 10 resident MAR's/TAR's to ensure staff initials/signatures are present for medications that were administered.

187a - Medication Record (continued)

Proposed Overall Completion Date: 10/20/2025

Directed Completion Date: 09/01/2025

Implemented [REDACTED] - 11/12/2025)

187d - Follow Prescriber's Orders

14. Requirements

2600.

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

Description of Violation

Resident #6 was prescribed Admelog Solostar, inject under the skin three times daily as per sliding scale: 150-200 = 2U, 201-250 = 4U, 251-300 = 6U, 301-350 = 8U, 351-400 = 10U, call provider if above 400. On 7/18/25 at 5:00 PM the resident had a blood glucose reading of 182. The resident was not administered any units of insulin.

Repeated Violation - 4/30/25, 4/1/25, 3/19/25 et al., 1/7/25 et al.

Plan of Correction

Accept [REDACTED] - 08/27/2025)

2600.187d – Follow Prescriber's Orders

- Facility is unable to correct violation for Resident #6.
- Education given by PCHA the week of 8/25/25 to all Med Techs and licensed staff on insulin sliding scale and following prescribers orders.
- Reportable completed on 8/20/25 for medication error found during DHS inspection.
- Starting the week of 8/25/25, audits will be conducted by RCC for 1 day per week for 10 weeks on all diabetic residents to ensure correct insulin units were provided based on blood sugar reading.

Licensee's Proposed Overall Completion Date: 08/27/2025

Implemented [REDACTED] - 11/12/2025)

225c - Additional Assessment

15. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #5's assessment, dated [REDACTED]/24, indicated a dietary need of "no added salt mechanical soft texture". However, on 4/1/25, an order was received for a "pureed diet with thickened liquids" and on 7/23/25, an order was received to change liquids from nectar thickened consistency to a honey thick liquid. Resident #5's assessment was never updated to reflect the dietary changes.

**225c - Additional Assessment (continued)**

Resident #6's assessment, dated [REDACTED]/25, indicated a dietary need for a mechanical soft diet. However, on 3/27/25, an order was received for a pureed diet. Resident #6's assessment was never updated to reflect the dietary changes.

**Plan of Correction****Accept [REDACTED] - 08/27/2025)****2600.225.c – Additional Assessment**

- PCHA updated support plan and DME on 8/18/25 for diet change on Resident #5
- PCHA updated support plan and DME on 8/18/25 for diet change on Resident #6
- Education provided by Executive Director to PCHA and RCC on 8/18/25 to ensure all support plans are updated with changes on all resident's.
- Initial audit of resident support plans will be conducted by RCC/PCHA to be completed by 9/5/25.
- Starting the week of 9/8/25, audits will be conducted by PCHA/RCC; 1x a week for 4 weeks and then 2x a month for 2 months on 5 residents to ensure support plan matches resident care needs.

Licensee's Proposed Overall Completion Date: 09/08/2025

**Implemented [REDACTED] - 11/12/2025)****227d - Support Plan Medical/Dental****16. 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**

Resident #5's support plan, dated [REDACTED]/24, indicated the resident self-propelled in a wheelchair for short distances and required total assistance for long distances. The resident's support plan did not document the resident's use of a Broda chair.

**Plan of Correction****Accept [REDACTED] - 08/27/2025)****2600.227.d – Support Plan Medical/Dental**

- PCHA updated support plan and DME on 8/18/25 for mobility needs on Resident #5
- Education provided by Executive Director to PCHA and RCC on 8/18/25 to ensure all support plans are updated with changes on all resident's.
- Initial audit of resident support plans will be conducted by RCC/PCHA to be completed by 9/5/25.
- Starting the week of 9/8/25, audits will be conducted by PCHA/RCC; 1x a week for 4 weeks and then 2x a month for 2 months on 5 residents to ensure support plan matches resident care needs.

Licensee's Proposed Overall Completion Date: 09/08/2025

**Implemented [REDACTED] - 11/12/2025)**