pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **2618 E MARKET STREET OPERATING COMPANY LLC**
LEGAL ENTITY

To operate **AUTUMN HOUSE EAST**
NAME OF FACILITY OR AGENCY

Located at **2618 EAST MARKET STREET, YORK, PA 17402**
(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 **150**
(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 32**

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 **November 14, 2025** until **November 14, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **338230**

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

EMAILING DATE: NOVEMBER 14, 2025

[redacted]
2618 E Market Street Operating Company LLC
[redacted]
[redacted]

RE: Autumn House East
2618 East Market Street
York, Pennsylvania 17402
License #: 33823

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on July 29, 2025, July 30, 2025, October 15, 2025 and October 16, 2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-Term Living

Enclosure
<Licensing Inspection Summaries>

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

November 14, 2025

2618 E MARKET STREET OPERATING COMPANY LLC

RE: AUTUMN HOUSE EAST
2618 EAST MARKET STREET
YORK, PA, 17402
LICENSE/COC#: 33823

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/15/2025, 10/16/2025 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: *AUTUMN HOUSE EAST* **License #**: *33823* **License Expiration**: *10/11/2025*

Address: *2618 EAST MARKET STREET, YORK, PA 17402*

County: *YORK* **Region**: *CENTRAL*

Administrator

Name:

Legal Entity

Name: *2618 E MARKET STREET OPERATING COMPANY LLC*

Address:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/27/2024* **Issued By**: *Labor & Industry*

Type: *I-1* **Date**: *08/11/2020* **Issued By**: *Springett bury Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *177* **Waking Staff**: *133*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Complaint, Interim* **Exit Conference Date**: *10/16/2025*

Inspection Dates and Department Representative

10/15/2025 - On-Site:

10/16/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *120*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Laurel Court* **Capacity**: *32* **Residents Served**: *31*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *120*

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

Have Mobility Need: *57* **Have Physical Disability**: *2*

Inspections / Reviews

10/15/2025 - Partial

Lead Inspector: **-Up Type**: *POC Submission* **Follow-Up Date**: *11/03/2025*

Inspections / Reviews *(continued)*

10/29/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *11/05/2025*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *11/05/2025*

10/30/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *11/05/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *11/18/2025*

11/14/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *11/05/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 10/15/25 at approximately 10:00 AM, Resident #1's list of medications were unlocked, unattended, and accessible in the A-hall kitchenette.

Repeated Violation - 12/11/24, et al

Plan of Correction ***Accept █ - 10/29/2025)***

Resident information was moved from the A-hall kitchenette on 10/15/25 by Resident Care Coordinator and filed appropriately. Resident Care Coordinator to perform daily audits of med carts and common areas to ensure confidentiality of residents' information. This audit will continue for one month beginning on 10/27/25. Nursing staff education regarding resident confidentiality to be done by the Director of Wellness and Resident Care Coordinator on 10/28/25.

Licensee's Proposed Overall Completion Date: *11/27/2025*

Implemented █ - 11/12/2025)

18 - Compliance With Laws

2. Requirements

2600.

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

Description of Violation

According to the Care Facility Carbon Monoxide Alarm Standards Act, if the approved CO alarm cannot be heard by the staff on duty on a specific floor or wing of the home, a single approved carbon monoxide alarm shall be installed where it can be heard by the staff on duty in addition to the alarm installed in close proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance. On 10/15/25 at 9:30 AM, a CO detector was not present on the first floor of the secured dementia care unit. The installed CO alarms could not be heard from this area. The home has fossil fuel boilers, dryers and a gas stove.

Plan of Correction ***Accept █ - 10/30/2025)***

Maintenance Director installed a new CO detector on the first floor of the secured dementia care unit on 10/15/25 while the inspector was present. Map of the building with the placement of all CO detectors was also given to the inspector on that date as well. Education was provided to the Maintenance Director on proper placement of CO detectors by the Administrator on 10/15/25. Maintenance Director to audit all CO detectors quarterly to ensure proper placement and that they are working properly. Audit to begin 11/1/25.

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

18 - Compliance With Laws *(continued)*

Implemented █ - 11/12/2025)

85b - Infestation

3. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 10/16/25 at approximately 2:00 PM, a mouse ran out from underneath Resident #3's closet and disappeared beneath the resident's baseboard heater.

Plan of Correction ***Accept █ - 10/30/2025)***

Maintenance Director had Ehrlich extermination company and lay bait traps in residents' room on 10/17/25. Education on Regulation 85b given to the Maintenance Director by the Administrator on 10/16/25. Maintenance Director to perform daily checks of the room and surrounding area to ensure no further rodent activity is noticed beginning on 10/18/25. These checks to continue for a one-month time period.

Licensee's Proposed Overall Completion Date: *11/18/2025*

Implemented █ - 11/12/2025)

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

November 14, 2025

2618 E MARKET STREET OPERATING COMPANY LLC

RE: AUTUMN HOUSE EAST
2618 EAST MARKET STREET
YORK, PA, 17402
LICENSE/COC#: 33823

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/29/2025, 07/30/2025 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: *AUTUMN HOUSE EAST* **License #**: *33823* **License Expiration**: *10/11/2025*

Address: *2618 EAST MARKET STREET, YORK, PA 17402*

County: *YORK* **Region**: *CENTRAL*

Administrator

Name:

Legal Entity

Name: *2618 E MARKET STREET OPERATING COMPANY LLC*

Address:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/27/2024* **Issued By**: *Labor & Industry*

Type: *I-1* **Date**: *08/11/2020* **Issued By**: *Springett bury Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *163* **Waking Staff**: *122*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Renewal, Provisional, Incident* **Exit Conference Date**: *07/30/2025*

Inspection Dates and Department Representative

07/29/2025 - On-Site:

07/30/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *114*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Laurel Court* **Capacity**: *32* **Residents Served**: *31*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *114*

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

Have Mobility Need: *49* **Have Physical Disability**: *1*

Inspections / Reviews

07/29/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/31/2025*

Inspections / Reviews *(continued)*

09/03/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/03/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/10/2025*

09/11/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/03/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/03/2025*

11/14/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/03/2025*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

18 - Compliance With Laws

1. Requirements

2600.

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

Description of Violation

The Influenza Awareness Act, effective July 2016, states that "Each facility shall ensure that the required influenza information is posted in a public place in the facility year-round." However, on 7/29/25, the home did not have a copy of the influenza awareness poster posted in a public place.

The home uses fossil fuel-burning devices for heating and to power the dryers. According to the Care Facility Carbon Monoxide Alarm Standards Act, effective September 2016, if the Carbon Monoxide (CO) alarm operates by a battery, the battery must be labelled with the date of installation and be replaced at least once annually. On 7/29/25, the batters of the CO alarms located in the basement, kitchen and B-hallway were last replaced on 8/30/23.

According to the Care Facility Carbon Monoxide Alarm Standards Act, if the approved CO alarm cannot be heard by the staff on duty on a specific floor or wing of the home, a single approved carbon monoxide alarm shall be installed where it can be heard by the staff on duty in addition to the alarm installed in close proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance. On 7/29/25, the D-hallway, G-hallway and H-hallway were not equipped with a CO alarm. The installed CO alarms could not be heard from these hallways.

Plan of Correction ***Accept [redacted] - 09/11/2025)***

Flu poster was obtained from the DHS website and posted in a public place by the Administrator on 7/29/25. Administrator to check for the flu poster daily beginning on 9/2/25. Administrator will replace if the poster is missing or becomes damaged. New CO detectors were placed throughout the building, including the D, G and H-hallways on 8/5/25 to be in compliance with the Care Facility Carbon Monoxide Alarm Standards Act. Maintenance Director to change the batteries in all detectors throughout the building every August starting in August of 2026. Maintenance Director to also check CO alarms for compliance on a quarterly basis beginning on 10/1/25. Education on CO detectors and proper maintenance of them, and flu poster compliance to be done by the Administrator at the staff meeting being held on 9/17/25.

[Directed]

- *In additional to the steps above, the CO alarms located in the basement, kitchen and B-hallway were replaced with new CO alarms by the Maintenance Director on 8/5/25.*

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented [redacted] - 11/14/2025)

25b - Contract Signatures

2. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

25b - Contract Signatures *(continued)*

Description of Violation

The resident-home contract, dated 25, for resident #1 was not signed by the resident.

The resident-home contract, dated /25, for resident #2 was not signed by the resident.

Plan of Correction ***Accept - 09/11/2025)***

Resident 2 signed the contract on /25 with the admissions coordinator. Resident 1 is currently on at the hospital and will be going to a rehab for some time. We do not have a specific time for return. will sign the contract upon returning to the facility. Education on the contract signing process was given to the admissions coordinator on 8/25/25 by the Administrator. Administrator to check all new contracts of residents upon move in for a three-month period beginning 8/25/25.

[Directed]

- *In addition to steps above, as of 9/10/25, resident #1 will not be returning to the home.*

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented - 11/14/2025)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Staff person A attempted to use Resident #3's credit at Starbucks on 6/6/25. As a result, staff person A was d. Three additional unauthorized purchases were made on resident #3's credit card prior to 6/2/25.

Repeated Violation - 4/29/25, et al and 12/11/24, et al

Plan of Correction ***Accept - 09/11/2025)***

Staff person A was following a thorough investigation by the Administrator on 6/6/25. Administrator will continue to investigate all allegations of theft throughout the building and keep written documentation of the investigations. Administrator to conduct monthly interviews with the residents regarding theft and safety at the Resident Council meetings being held every month beginning with the September meeting. All allegations and investigation results will be reported to DHS and AAA in a timely manner. Education on Resident Rights and Abuse to be done by the Administrator at the staff meeting being held on 9/17/25.

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

Implemented - 11/14/2025)

54a - Direct Care Staff

4. Requirements

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

Description of Violation

Staff person B, hired on [redacted] 25, did not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept [redacted] - 09/11/2025)***

Staff person B has a high school diploma and a college degree from [redacted] of the United States. Request for a waiver from DHS to allow the staff member to continue working in [redacted] same capacity was sent on 8/25/25. Staff member has been removed from the schedule at this time. Awaiting response from DHS. Human Resources Director to audit all staff files to ensure compliance with 54.a. Audit to begin the week of 9/2/25. HRD to also do quarterly audits of all new hires to ensure compliance beginning on 10/1/25. Education was provided to all hiring staff on proper documents needed for new hires in each department by the Administrator at the stand-up meeting on 8/25/25.

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

Implemented [redacted] 11/14/2025)

63a - First Aid/CPR Training

5. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

From 7/17/25 at 10:45 PM until 7/18/25 at 7:15 AM, 114 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid and CPR.

From 7/18/25 at 10:45 PM until 7/19/25 at 7:15 AM, 114 residents were present in the home. During this time only 2 staff persons were present in the home who was certified in first aid and CPR.

From 7/19/25 at 10:45 PM until 7/20/25 at 7:15 AM, 114 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid and CPR.

Plan of Correction ***Accept [redacted] - 09/11/2025)***

CPR and first-aid classes were held on 8/12/25 and 8/22/25 to get the proper amount of CPR and first-aid certified staff members. Classes will continue to be held throughout this year and next to ensure ongoing compliance with Regulation 63.a. Audit was completed of all CPR and first-aid certified staff members to ensure compliance by Dementia Program Director on 8/22/25. Director or Wellness to monitor schedules to ensure compliance with 63.a prior to posting all schedules beginning on 9/2/25. Education on requirements for the number of staff that needs to be CPR and first-aid certified for the safety of our residents to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

63a - First Aid/CPR Training *(continued)*

Implemented [redacted] - 11/14/2025)

65f - Training Topics

6. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff person C, hired on [redacted]/14, did not receive training in the following topics during the 2024 training year:
- *Medication self-administration training.*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*
- *Safe management techniques.*
- *Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.*

Staff person D, hired on [redacted]/22, and staff person E, hired on [redacted]/17, did not receive training in the following topics during the 2024 training year:
- *Medication self-administration training.*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*
- *Personal care service needs of the resident.*
- *Safe management techniques.*
- *Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.*

Staff person F, hired on [redacted]/13, did not receive training in the following topics during the 2024 training year:
- *Medication self-administration training.*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*
- *Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.*
- *Personal care service needs of the resident.*
- *Safe management techniques.*
- *Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.*

Plan of Correction ***Accept [redacted] - 09/11/2025)***

Staff members C, D, and F have received all the indicated for 2025. The root cause of this issue was the former Human Resources Director had very poor organizational skills and did not properly file training records. That Human Resources Director is no longer an employee with Autumn House East, and the new Human Resource Director audits [redacted] files monthly along with our Regional Human Resource Director to ensure that this issue does

65f - Training Topics (continued)

not occur again. Administrator will audit all staff training topics weekly to ensure all topics are being covered and staff is up to date with current 2025 annual trainings beginning on 8/25/25. Audit to last for a three-month period. Monthly staff meetings are being held to ensure that all staff is getting the proper amount of training for 2025. Education on annual training topics to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented 11/14/2025)

65g - Annual Training Content

7. 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).

Description of Violation

Staff person C, hired on /14, did not receive training in the following topics during the 2024 training year:

- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *Resident rights.*
- *The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).*

Staff person D, hired on /22, staff person E, hired on /17, and staff person F, hired on /13, did not receive training in the following topics during the 2024 training year:

- *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.*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *Resident rights.*
- *The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).*

Plan of Correction ***Accept - 09/11/2025)***

Staff members C, D, and F have received all the indicated for 2025. The root cause of this issue was the former Human Resources Director had very poor organizational skills and did not properly file training records. That is no longer an employee with Autumn House East, and the new Human Resource Director audits files monthly along with our Regional Human Resource Director to ensure that this issue does not occur again. Administrator will audit all new hire training topics weekly to ensure all topics are being covered beginning on 8/25/25. Audit to last for a three-month period. Education on annual training topics to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented - 11/14/2025)

82c - Locking Poisonous Materials

8. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 7/30/25, a container of optic white toothpaste, a container of sparkle fresh toothpaste and a bottle of Aveeno lotion, all with a manufacture's label indicating "contact poison control center if ingested", were unlocked, unattended, and accessible in resident #1's room. Not all the residents of the home, including resident #1, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept - 09/11/2025)***

Received order from Resident 1's physician was obtained stating that she can safely use poisonous materials on 8/22/25. DME and support plan were changed to reflect those changes by the Director of Wellness on 8/22/25. Director of Wellness to ensure that all residents are being assessed properly for safety around poisonous materials. Audits of all DMEs to ensure current residents are properly assessed to be done by the DOW beginning on 9/1 until all residents are completed. To be done by 9/30/25. Quarterly audits of DMEs to be done by the Administrator to ensure ongoing compliance to begin on 10/1/25. Education on resident assessment and safety around poisonous materials to be done by the Administrator at the staff meeting being held on 9/17/25.

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

Implemented - 11/14/2025)

85a - Sanitary Conditions

9. Requirements

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

Description of Violation

On 7/30/25, there was an uncovered, half full urinal hanging off of resident #2's nightstand drawer.

On 7/30/25, there was brown fecal matter located on the grab bar and toilet paper holder in resident #4's bathroom. There were also brown stains on the wall behind the toilet.

On 7/30/25, the door and door handle of resident #5's bedroom had a few dark brown/red spots on the door. The resident's bedroom floor was heavily covered with food, dirt and debris.

Plan of Correction ***Accept - 09/03/2025)***

The affected areas for residents #4 and #5 were cleaned by housekeeping staff on 7/30/25. Urinal for resident #2 was emptied, cleaned, and covered by the nursing staff on the same date. Housekeeping director to do daily audits of building beginning on 8/25/25 to identify immediate unsanitary conditions. This audit to be done for a two-month time. Education on proper sanitary conditions and the importance of timely cleaning to be done by the

85a - Sanitary Conditions (continued)

Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/25/2025*

Implemented █ - 11/14/2025)

88a - Surfaces

10. 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 7/29/25, at 11:10 AM, the side egress door from the H-hallway was missing the threshold, leaving the subflooring exposed. There was also a two-inch drop from the door frame to the floor, creating a tripping hazard.

On 7/29/25, there were multiple exposed electrical wires hanging from an air conditioning unit located in the first-floor Secure Dementia Care dining room.

Plan of Correction ***Accept █ - 09/11/2025)***

H-hallway egress door was repaired to cover the subfloor, and drop was filled in by the Maintenance Director on 8/1/25. Monthly audits of the building to be done by the Maintenance assistant to ensure ongoing compliance with regulation 88.a beginning on 9/1/25. Electrical wires were secured to the air conditioning unit by the Maintenance Director on the same date. Education on identifying and proper reporting in our TELS system to be done by the Administrator and the Maintenance Director at the staff meeting being held on 9/17/25.

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

Implemented █ - 11/14/2025)

95 - Furniture and Equipment

11. Requirements

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

Description of Violation

On 7/29/25, at approximately 10:20 AM, the lid of the chest freezer located in the kitchen's dry storage room did not close due to the buildup of ice around the entire freezer.

On 7/30/25, water was continuously dripping from the bathroom sink faucet in resident #6's bathroom. At the time, both knobs were completely turned off, but the water was still running.

95 - Furniture and Equipment (continued)

Plan of Correction ***Accept ███ - 09/11/2025)***

Buildup of ice was removed by Maintenance Director on 8/6/25, allowing the chest freezer lid to close properly. Kitchen staff to alert maintenance through the TELs system if ice buildup resumes and new chest freezer will be ordered at that time. New faucet was installed in Resident 6's bathroom by the Maintenance Director on 8/7/25. Maintenance director to audit freezer for ice build-up and leaky faucets monthly to ensure they are working properly. Audits to last for a 3 month time. Education on reporting any equipment not working properly through our TELs system to be done by the Administrator and Maintenance Director to be done at the staff meeting being held 9/17/25.

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

Implemented ███ - 11/14/2025)

97 - Elevators/Lifting Devices

12. Requirements

2600.

97. Elevators and Stair Glides - Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

Description of Violation

On 7/29/25, the two elevators in the home did not have a current certificate of operation from the Department of Labor and Industry or appropriate local building authority.

Plan of Correction ***Accept ███ - 09/11/2025)***

Elevators are currently awaiting on two repairs that need the Department of Labor to be a part of. Autumn House and TK elevator service is waiting a date and time for this to happen for one elevator, and the other is scheduled for 8/29/25. On 9/18/25, an email was received from TK elevator service stating that the request for inspection has been submitted and they are awaiting a response from the Department of Labor. Once the repairs are done, then the Department of Labor will inspect both elevators. Administrator to audit elevators quarterly to ensure that inspections are being scheduled at the proper times. Education on elevator inspections to be done by the Administrator and Maintenance Director at the staff meeting being held on 9/17/25.

[Directed]

- *In addition to the steps above, both elevators are scheduled to be inspected by TK elevator company on 9/11/25.*

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

Implemented ███ - 11/14/2025)

103e - Left Overs

13. Requirements

2600.

103e - Left Overs *(continued)*

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 7/29/25, there were 4 unlabeled and undated plastic containers of various cereals in the kitchen.

Plan of Correction ***Accept (- 09/02/2025)***

Cereal containers were properly labeled and dated by dietary staff on 7/29/25. Daily audits of the kitchen to ensure proper labeling and dating to be done by the Executive Chef or the cook on duty beginning on 8/25 and continuing for one month. Education on proper labelling and dating to be done by the Administrator and Executive Chef to be provided at the staff meeting taking place 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented - 11/14/2025)

103f - Refrigerator/Freezer Temps

14. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 7/29/25, at approximately 10:20 AM, there was no thermometer in the chest freezer located in the kitchen dry storage room.

Plan of Correction ***Accept - 09/02/2025)***

Thermometer was found at the bottom of the freezer and moved to a more conspicuous place by the Executive Chef on 8/30/25. Daily audit of the chest freezer to be completed by the Executive Chef or cook on duty to ensure placement of the thermometer beginning on 8/25/25. Audit to last for one month time. Education on proper placement and recording of freezer and refrigerator temps to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented - 11/14/2025)

103g - Storing Food

15. Requirements

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

Description of Violation

On 7/29/25, at 10:15 AM, an opened jar of grape Smucker's jelly with a label indicating refrigerate after opening, was stored on a dry food storage rack in the kitchen.

On 7/29/25, at 11:00 AM, 12 plastic cups of uncovered pretzels were in the drawer of one of the cabinets in the B-hallway activity room.

103g - Storing Food *(continued)*

Plan of Correction ***Accept [redacted] - 09/11/2025)***

Grape jelly was placed back into the refrigerator on 7/29/25 by a Dietary employee. Uncovered pretzels were disposed of by the Activities Director on the same date. Daily audits of the kitchen to ensure items are stored properly to be done by the Executive Chef or the cook on duty beginning on 9/1/25. Audits to continue for one month. Activities Director to ensure that her snacks are covered prior to her giving them out at the planned activity. Activities Director to audit activities room kitchenette daily to ensure all snacks are covered beginning on 9/1/25. Education on proper storage of perishable items to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented [redacted] - 11/14/2025)

121a - Unobstructed Egress

16. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 7/29/25, at 10:28 AM, the A-hallway exit door was partially blocked by a wheelchair and walker.

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

Wheelchair and walker were moved away from the A-hall exit door by housekeeping staff on 7/29/25. Weekly audits of all exit doors to ensure they are unobstructed to be done by the Administrator beginning on 8/25/25 and will continue for one month. Education on making sure that all exit doors are unobstructed to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented ([redacted] - 11/14/2025)

132e - Fire Drill Sleeping Hours

17. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 1/31/24 at 5:30 AM.

Plan of Correction ***Accept [redacted] - 09/11/2025)***

A sleeping hours fire drill was held on 7/31/25. Education was provided to the Maintenance Director on fire drill requirements by the Administrator on 7/30/25. Maintenance Director made a schedule of fire drills for the remainder of 2025 and the first six months of 2026 to ensure drills are being held at proper times. Administrator to audit fire drill documentation monthly beginning on 9/23/25. Education on off-shift fire drills to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/23/2025*

Implemented [redacted] - 11/14/2025)

141a - Medical Evaluation

18. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #6 was admitted to the home on [redacted]/24. However, the resident's initial medical evaluation was completed on 9/19/24.

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

New DME was sent to Resident 6's physician on 8/26/25. Awaiting on physician to fill out at this time. Director of Wellness to ensure all DMEs are dated correctly on all new admissions beginning on 8/25/25. Administrator to audit all DMEs on a monthly basis beginning 9/1/25. Education on proper dating of DMEs to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented [redacted] - 11/14/2025)

144c1 - Smoking Area Guidelines

20. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 7/29/25, at 9:44 AM, 28 cigarettes were in a cement planter located in the Secure Dementia Care Unit (SDCU) courtyard. The SDCU courtyard is not a designated smoking area.

Repeated Violation - 12/11/24, et al

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

Cigarette butts were disposed of by the Dementia Program Director on 7/29/25. The resident that was responsible for the smoking in the SDCU moved out of the facility on 8/1/25. Nol further smoking has happened in the SDCU since that time. Audits of the SDCU courtyard to check for cigarettes and anyone smoking to be done by the DPD and Memory Care Coordinator starting on 8/25/25 and continuing for one month. Education on proper smoking areas to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/25/2025*

Implemented [redacted] - 11/14/2025)

181c - Self-administration Assessment

21. Requirements

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

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #7 self-administers medications to include Nyquil and No-drip nasal spray; however, resident #7 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept - 09/02/2025)***

Nyquil and nasal spray were taken from the Resident 7's room by the Resident Care Coordinator on 7/30/25. Medications have since been administered by the nursing staff. Audits of resident rooms to ensure that no medications are in the rooms of residents, prescribed or otherwise, unless we have orders stating otherwise. Audits to be done by the DOW and the Resident Care Coordinator beginning on 8/25/25 and will last for two months. Education on medications and self-administering to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/25/2025*

Implemented - 11/14/2025)

181d -Storing Medication

22. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #6 self-administers medications and stores medications in room. On 7/30/25, there were several unlocked, unattended medications to include a tube of Neosporin, a bottle of Doxazosin Mesalate 2mg, a bottle of Colace stool softener, a bottle of vitamin D3 and a bottle of Amlodipine 10mg in resident #6's bedroom.

Plan of Correction ***Accept - 09/02/2025)***

Education was provided to the resident and family regarding keeping the door to locked to ensure the safety of medications by the Administrator on 7/30/25. Resident and family voiced understanding of the education. Administrator to check resident 6's room daily beginning on 8/25/25 to ensure that it is locked for a one-month time frame. Education on Regulation 181.d to be provided by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/25/2025*

Implemented - 11/14/2025)

181f - Record of Medication

23. Requirements

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

Description of Violation

On 7/30/25, resident #6's medication list in the resident's record did not include Neosporin, Thera Worx muscle cramps foam and Vitamin D3, all of which were located in the resident's room.

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

Neosporin, There Worx, and Vitamin D3 were removed from the resident 6's room by the Resident Care Coordinator on 7/30/25. Director of Wellness sent a fax requesting these orders to the physician on 8/25/25. Awaiting response from physician at this time. DOW to do monthly audits with all residents that self-administer medications to ensure that all medications have an order from the physician beginning on 9/1/25. Education on residents and self-administering medications to be done by the Administrator and DOW at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented [redacted] - 11/14/2025)

183b - Meds and Syringes Locked

24. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident’s room.

Description of Violation

On 7/29/25, at 10:00 AM, there was a yellow, oval gel tablet lying on the floor of the D-shower room, which was unlocked.

On 7/29/25, at 1:19 PM, there was a yellow, oval gel tablet on the carpet in hallway in front of resident room [redacted].

Repeated Violation - 12/11/24, et al

Plan of Correction ***Accept [redacted] - 09/11/2025)***

Both medications were disposed of by the Administrator on 7/29/25. Daily audits of med rooms and hallways to be completed by Nursing Managers to ensure there are no medications are on the floor starting on 8/25/25 and continuing for one month. Education on medication administration procedures to be done by the Administrator and Director of Wellness to be done at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented [redacted] - 11/14/2025)

183e - Storing Medications

25. Requirements

2600.

183e - Storing Medications *(continued)*

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 7/30/25, an opened Lantus insulin pen prescribed for resident #8 did not have an open date.

On 7/30/25, a bottle of Famotidine 20mg prescribed as needed for resident #8 expired on 4/29/25.

On 7/30/25, a bottle of Melatonin 10mg prescribed as needed for resident #9 expired on 6/16/24.

On 7/30/25, a bottle of Guaifenesin 100mg/ml prescribed as needed for resident #10 expired on 6/20/25.

On 7/30/25, an opened Novolog Flex insulin pen prescribed for resident #11 did not have an open date.

On 7/30/25, an opened Basaglar insulin pen prescribed for resident #12 did not have an open date.

Repeated Violation - 12/11/24, et al

Plan of Correction ***Accept ██ - 09/11/2025)***

Insulin pens without open dates and expired medications were disposed of by the Director of Wellness on 7/30/25. DOW and Resident Care Coordinator to perform bi-weekly medication cart audits beginning the week of 8/25/25 to ensure there are no expired medications or unlabeled insulin pens. Audits to continue for two months. Pharmacy to conduct quarterly medication cart audits to ensure the same beginning on September 16th. Education on expired meds, proper labeling of medications, and medication re-ordering procedures to be done by the Administrator and DOW at the staff meeting being held on 9/17/25.

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

Implemented ██ - 11/14/2025)

186a - Authorized Prescriber

26. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

The prescription medication Zinc Oxide belonging to resident #13 did not have a current order from an authorized prescriber.

Plan of Correction ***Accept ██ - 09/11/2025)***

Zinc Oxide was removed from Resident 13's room by the Director of Wellness on 7/30/25. Order was obtained from the physician the following day and medication was put into the med cart. Audits of resident rooms to ensure that no medications are in the rooms of residents, prescribed or otherwise, unless we have orders stating otherwise. Audits to be done by the DOW and the Resident Care Coordinator beginning on 8/25/25 and will last for two

186a - Authorized Prescriber (continued)

months. Education on following prescriber's orders to be done by the Administrator and Director of Wellness at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented [redacted] - 11/14/2025)

187d - Follow Prescriber's Orders

27. Requirements

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

Description of Violation

Resident #7 is prescribed Prednisolone 10mg with orders to take one tablet once daily. However, this medication was not administered to resident #7 from 7/21-7/29/25 because the medication was not available in the home.

Repeated Violation - 4/29/25, et al and 12/11/24, et al

Plan of Correction ***Accept [redacted] - 09/03/2025)***

Medication was obtained from the pharmacy on 7/29/25 and administered as prescribed. Director of Wellness will review all new prescriptions at the time of admission or physician order to confirm medications are available in the home prior to the next scheduled dose. The med techs will maintain a daily log of medication deliveries from the pharmacy to ensure timely receipt. Weekly audit of active orders to be done by the Resident Care Coordinator to verify that all medications are present and administered as directed beginning 8/25/25. Audit to last for two months. Education on ordering and receiving medications to be done by the Administrator and DOW at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/25/2025*

Implemented [redacted] - 11/14/2025)

190a - Completion Medication Course

28. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C's 2024 annual practicum form had one medication record review and one medication administration observation completed by the trainer in December of 2024. There was a second medication record review and a second medication administration observation completed by staff person G in June of 2025. However, staff person G is not a certified medication administration trainer or practicum observer. Staff person C administered insulin to resident #2 on 7/17/25, at 4:00 PM and 7:30 PM.

Staff person E has not successfully completed a Department-approved medications administration course. Staff person E administered insulin to resident #2 on 7/17/25, at 7:00 AM and 11:00 AM.

190a - Completion Medication Course (continued)

Staff person H's 2024 annual practicum form had one medication record review and one medication administration observation completed by the trainer in October of 2024. There was a second medication record review and a second medication administration observation completed by staff person G in April of 2025. However, staff person G is not a certified medication administration trainer or practicum observer. Staff person H administered Quetiapine to resident #1 on 7/8/25, at 8:00 AM and 12:00 PM.

Repeated Violation - 12/11/24, et al

Plan of Correction ***Accept ██ - 09/11/2025)***

Staff members C, H, and E will have the medication administration course completed by 9/1/25 and will have all observation reviews done by a certified medication administration trainer from then on. All med techs are in the process of getting re-certified by the certified trainer at this time. Re-certifications to be completed by 9/12/25. All other med tech observations to be done by a certified trainer in the future. Education on med tech trainings and observations to be done by the Administrator and Director of Wellness at the staff meeting being held on 9/17/25.

[Directed]

- *In addition to the above steps, the Administrator, Director of Wellness or designee will complete quarterly audits of all current med techs' certifications to ensure compliance. This will begin no later than 10/12/25. Documentation of these audits will be kept and available for review by the Department.*

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented ██ - 11/14/2025)

190b - Insulin Injections

29. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person C's 2024 annual practicum form had one medication record review and one medication administration observation completed by the trainer in December of 2024. There was a second medication record review and a second medication administration observation completed by staff person G in June of 2025. However, staff person G is not a certified medication administration trainer or practicum observer. Staff person C administered insulin to resident #2 on 7/17/25, at 4:00 PM and 7:30 PM.

Staff person E has not successfully completed a Department-approved medications administration course. Staff person E administered insulin to resident #2 on 7/17/25 at 7:00 AM and 11:00 AM.

Repeated Violation - 12/11/24, et al

190b - Insulin Injections *(continued)*

Plan of Correction ***Accept (- 09/11/2025)***

Staff members C and E will have the medication administration course completed by 9/1/25 and will have all observation reviews done by a certified medication administration trainer from then on. All med techs are in the process of getting re-certified by the certified trainer at this time. Re-certifications to be completed by 9/12/25. All other med tech observations to be done by a certified trainer in the future. Education on med tech trainings and observations to be done by the Administrator and Director of Wellness at the staff meeting being held on 9/17/25.

[Directed]

- *In addition to the above steps, the Administrator, Director of Wellness or designee will complete quarterly audits of all current med techs' certifications to ensure compliance. This will begin no later than 10/12/25. Documentation of these audits will be kept and available for review by the Department.*

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented (- 11/14/2025)

231c - Preadmission Screening

31. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #14 was admitted to the Secure Dementia Care Unit on /25. However, the resident's written cognitive preadmission screening was completed on /25.

Plan of Correction ***Accept (- 09/02/2025)***

Director of Wellness to ensure all pre-admission screenings for the secured dementia unit are dated correctly on all new admissions beginning on 8/25/25. Administrator to audit all pre-admission screenings for the SDCU on a monthly basis beginning 9/1/25. Education on proper dating of pre-admission screenings for the SDCU to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *09/17/2025*

Implemented (- 11/14/2025)

233c - Key-Locking Devices

32. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 7/29/25, at 9:33 AM, the directions for operating the home's locking mechanism were not conspicuously posted near the door exiting the Secure Dementia Care Unit (SDCU) to the main hallway on the first floor.

On 7/29/25, at 9:35 AM, the directions for operating the home's locking mechanism were not conspicuously posted near the side exit door located in the SDCU.

233c - Key-Locking Devices (continued)

Plan of Correction ***Accept (- 09/02/2025)***

Directions for the locking mechanisms were posted by the exit door to the SDCU and the side exit door by the Dementia Care Coordinator on 7/29/25. Weekly audits of all locking mechanisms to ensure directions are posted to be done by the Memory Care Coordinator beginning on 8/25/25 and will continue for one month. Education on the importance of the directions and reporting missing directions to be done by the Administrator at the staff meeting being held on 9/17/25.

Licensee's Proposed Overall Completion Date: *10/25/2025*

Implemented (- 11/14/2025)