pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **GRAYSFUL LIVING LLC**
LEGAL ENTITY

To operate **GRAYSFUL LIVING LLC**
NAME OF FACILITY OR AGENCY

Located at **45 SOUTH MT. VERNON AVE., UNIONTOWN, PA 15401**
(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 **29**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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 **October 22, 2025** until **April 22, 2026**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **456421**

ISSUING OFFICER

ACTING 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 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 22, 2025

[redacted]
Graysful Living LLC
45 South Mt. Vernon Avenue
Uniontown, Pennsylvania 15401

RE: Graysful Living LLC
License #456421

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on July 29, 2025, and October 1, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance #456420 dated April 30, 2025 – April 30, 2026, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 22, 2025 to April 22, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675

PH: 717-265-8942

This decision is final 31 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *GRAYSFUL LIVING LLC* **License #:** *45642* **License Expiration:** *04/30/2026*

Address: *45 SOUTH MT. VERNON AVE., UNIONTOWN, PA 15401*

County: *FAYETTE* **Region:** *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *GRAYSFUL LIVING LLC*

Address: *45 SOUTH MT. VERNON AVE., UNIONTOWN, PA, 15401*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date:** *05/11/1981* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *11* **Waking Staff:** *8*

Inspection Information

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

Reason: *Renewal, Complaint, Monitoring* **Exit Conference Date:** *07/29/2025*

Inspection Dates and Department Representative

07/29/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *29* **Residents Served:** *10*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *10* **Are 60 Years of Age or Older:** *9*

Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability:** *4*

Have Mobility Need: *1* **Have Physical Disability:** *2*

Inspections / Reviews

07/29/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/17/2025*

Inspections / Reviews *(continued)*

08/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/10/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/22/2025*

09/03/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/10/2025*

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

10/06/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/10/2025*

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

3c - Post Current License

1. Requirements

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

Description of Violation

At the time of inspection, the following items were not posted in a conspicuous and public place in the home:

- *The home's current license, dated 4/30/25 through 4/30/26*
- *A copy of the Personal Care Home, Chapter 2600 regulations*

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

Administrator immediately printed and posted current license and a copy of the Personal Care Home Chapter 2600 regulations obtained from licensing rep on 7/29/25. Administrator and staff will monitor weekly starting 8/13/25 to ensure current license and PCH Chapter 2600 Regulations are in a conspicuous place at all times. Administrator will keep documentation of weekly checks. All staff will receive education on mandatory posted items on 8/29/25. Documentation of education will be kept.The next scheduled quality management is scheduled for 9/05/2025 and a review of all items specified in 2600.26b will take place at that time. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/05/2025*

Implemented [redacted] - 10/06/2025)

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.

Description of Violation

Resident #3's resident-home, dated [redacted]/25, is not signed by resident #3.

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

Contract was immediately signed by resident and placed in residents file on 7/29/2025. Administrator to monitor and maintain all proper contracts and paperwork is completed per state laws and safely stored monthly.All new resident files will be reviewed within 30 days of contract. Administrator has reviewed all other resident files completed on 8/8/25 to ensure all files are completed per regulations. All staff will receive education on how to review a resident file so that more than one person is checking files to ensure completion. Education will be completed by 08/29/2025, by all staff. All Documentations will be kept.

Licensee's Proposed Overall Completion Date: *09/05/2025*

Implemented [redacted] - 10/06/2025)

51 - Criminal Background Check

3. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

51 - Criminal Background Check *(continued)*

Description of Violation

No Pennsylvania criminal background check was completed for direct care staff person B, who was hired on [redacted]/25.

No Pennsylvania criminal background check was completed for direct care staff person C, who was hired on [redacted]/25.

No Pennsylvania criminal background check was completed for staff person D, who was hired on [redacted]/25.

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

Criminal Backgrounds were completed on 7/30/25 but not on the correct site. While looking for the confirmation to print today Administrator realized this. The correct criminal background site was used today and confirmation letters of record/under review were printed. (DIRECTED: By 9/5/25: The administrator shall ensure the completed Pennsylvania criminal background checks are present in staff persons B, C and D's records. [redacted]9/3/25). A new employee checklist has been created for each staff file on 8/28/25 and were be placed in staff files on 8/29/2025. All staff files are being reviewed to be completed by 8/29/2025. All new files will be reviewed within 30 days of hire. All staff files will be reviewed every 90 days starting 8/29/25 to make sure staff is up to date. All staff will receive education on what they need to be compliant on 8/29/25. Documentation will be kept.

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *09/05/2025*

Not Implemented [redacted] - 10/06/2025)

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

No high school diploma, GED or active registry status on the Pennsylvania nurse aide registry was present for direct care staff person C, hired on [redacted]/25. Direct care staff person C regularly provides ADL assistance to residents.

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

Appropriate documentation, high school transcripts, has been obtained via employee and placed in staff records on 7/30/2025. (DIRECTED: By 9/5/25: The administrator shall ensure direct care staff person C's qualifications specified in 2600.54a are present in their record. [redacted] 9/3/25). Administrator to ensure all appropriate documentation is obtained in a timely manner and in designated staff file every 3 months starting 8/29/25, documentation will be kept. Administrator completed overview of all staff files to ensure proper documentation is in place on 8/8/25. All hired staff will receive employee education to completed by 07/29/2025. A new hire checklist has been developed on 08/28/2025 and implemented on 08/29/2025. Checklist will be kept in the front of each staff file.

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *09/05/2025*

Not Implemented [redacted] - 10/06/2025)

60a - Staff/Support Plan

5. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home routinely does not have a staff person present in the home who is qualified to administer medications. The home's only staff person who is qualified to administer medications is staff person A, the home's administrator. Numerous residents present in the home are unable to self-administer medications and are prescribed pro re nata (PRN) medications, including the following:

- *Resident #1, who is currently prescribed Albuterol HFA Inhaler-Inhale 1 to 2 puffs every 6 hours as needed for shortness of breath/wheezing, as well as currently prescribed Ondansetron 4mg tablet-Take 1 tablet by mouth every 8 hours as needed for nausea/vomiting*
- *Resident #2, who is currently prescribed Hydroxyzine HCL 25mg tablet-Take 1 tablet by mouth every 8 hours as needed for itching, as well as currently prescribed Ondansetron 4mg tablet-Take 1 tablet by mouth every 8 hours as needed for nausea/vomiting*
- *Resident #5, who is currently prescribed APAP 500mg tablet-Take 1 tablet by mouth every 4 hours as needed for pain/headache, as well as currently prescribed Loperamide 2mg capsule-Take 1 tablet by mouth every 4 hours as needed for diarrhea*

The home does not have a staff person present in the home who has successfully completed the Department-approved diabetes patient education program within the past 12 months; however, resident #2 is currently prescribed Novolog Flexpen insulin-Inject subcutaneously 3 times daily in accordance with sliding scale coverage. According to resident #2's assessment, dated [redacted]/25, resident #2 is unable to self-administer medications.

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

state approved diabetes patient education program has been planned, scheduled, and completed by all staff on 8/13/2025. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.190c. [redacted] 9/3/25). Administrator will place completed certs. in staff designated file, when received via mail by trainer. All hired staff at this time is med certified with the exception of one. Staff member that is uncertified in med administration training, is always now working with a second employee that is med certified at this time. This staff person has started the online course for medication administration on 8/22/25. My train-the-trainer is [redacted] will ensure all staff certifications/trainings are reviewed every 3 months to ensure no lapses in trainings shall occur. Documentation will be kept. (DIRECTED: Documentation of all medication training shall be kept in accordance with the Department-approved medication administration course and in accordance with 2600.190c. [redacted] 9/3/25). Staff education to be completed by 8/29/2025, all hired staff to complete training so that they are aware what they need to stay in compliance as well.

DIRECTED: By 9/10/25: The administrator shall develop and implement a tracking system which includes the dates each direct care staff persons has successfully completed the Department-approved medication course specified in 2600.190a, as well as the dates all annual practicums have been completed in accordance with the Department-approved medication administration course. The tracking system shall also include the dates each direct care staff person has successfully completed the Department-approved diabetes patient education program in accordance with 2600.190b. Documentation of the tracking system shall be kept. Beginning on 10/1/25, the administrator shall review the tracking system quarterly to ensure compliance with 2600.60a, 2600.190a and 2600.190b. [redacted] 9/3/25

DIRECTED: Beginning on 9/5/25: The administrator shall review the direct care staffing schedule daily to ensure compliance with 2600.60a and to ensure a staff person qualified to administer medications is present in the home

60a - Staff/Support Plan (continued)

at all times. [redacted] 9/3/25

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *09/10/2025*

Not Implemented [redacted] - 10/06/2025)

62 - Contact List

6. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

At the time of inspection, staff person A, the home's administrator, did not have a current list of the names, addresses and telephone numbers of staff persons, including substitute personnel and volunteers.

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

Administrator obtained all required staff information, creating a staff list that provides current names, addresses, and telephone numbers on 07/29/2025. Administrator to review with staff every 90 days for any changes that need to be reported. Auditing was completed on 08/15/2025. Documentation will be kept. Administrator will implement the changes to ensure all staff info is up to date staff education to be completed by 08/29/2025 to be sure the staff knows to report any changes as soon as possible.

Licensee's Proposed Overall Completion Date: *08/29/2025*

Not Implemented [redacted] - 10/06/2025)

64a - Admin Training

7. Requirements

2600.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
2. A 100-hour standardized Department-approved administrator training course.

Description of Violation

There is no documentation present indicating staff person A, the home's administrator, has successfully completed the 100-hour Department-approved administrator training course.

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

Certificate of completion of 100-hour department approved administrator training course was printed and placed in designated staff file on 07/29/2025.. certification is hung in designated area in plan view as of 07/29/2025.. Administrator to review staff files every 3 months to ensure all necessary documentation are in place.Initial auditing completed on 7/29/2025. Administrator will review chapter 2600.64 and ensure [redacted] is educated on all required documentation and where they should be by 8/29/2025.

Licensee's Proposed Overall Completion Date: *08/29/2025*

Implemented [redacted] 10/06/2025)

65a - FS Orientation 1st Day

8. 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

Direct care staff person B, hired on [redacted]/25, did not receive orientation on any of the topics specified in 2600.65a.

Direct care staff person C, hired on [redacted]/25, did not receive orientation on any of the topics specified in 2600.65a.

Ancillary staff person D, hired on [redacted]/25, did not receive orientation on any of the topics specified in 2600.65a.

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

First day Orientation papers were created on 8/5/25. Staff received orientation from Administrator on 8/6/2025. Documentation will be kept. Administrator to ensure all new staff receives first day orientation prior to first day or on the first day. Administrator printed and hung the yearly training plan on 8/05/25 to be implemented immediately. All staff records were reviewed on 7/29/2025 and missing items were completed and documentation kept on 8/6/2025. Administrator will audit staff files again monthly and keep documentation of reviews.A New hire Checklist has been implemented as of 8/28/2025 and placed in the front of each staff file. (DIRECTED: Immediately: The new hire checklist shall be implemented to ensure all newly-hired staff persons receive orientation on all topics specified in 2600.65a prior to or during the first workday. Documentation of the training and the completed new hire checklists shall be kept in each staff person's record. [redacted] 9/3/25).

DIRECTED: By 9/5/25: The administrator shall ensure staff persons B, C and D have received orientation on all topics specified in 2600.65a. Documentation of the education shall be kept in each staff person's record in accordance with 2600.65i. [redacted] 9/3/25

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *09/05/2025*

Implemented ([redacted] - 10/06/2025)

65b - Rights/Abuse 40 Hours

9. Requirements

2600.

65b - Rights/Abuse 40 Hours *(continued)*

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Direct care staff person B, hired on [redacted]/25, did not receive orientation on any of the topics specified in 2600.65b.

Direct care staff person C, hired on [redacted]/25, did not receive orientation on any of the topics specified in 2600.65b.

Ancillary staff person D, hired on [redacted]/25, did not receive orientation on any of the topics specified in 2600.65b.

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

Administrator to ensure all staff is properly educated prior to first day or on the first day of. Orientation to keep staff in ordnance with state regulation code 2600.65i, training will be provided to all required staff on 8/29/2025, provided by administrator. Administrator to create yearly training plan to ensure all training to completed upon new hire. Administrator to begin auditing staff files on 08/01/2025. Administrator to review staff files every 3 months, required changes will be implemented on 8/01/2025. Administrator to ensure to collect staff signature after completion of each training. All documentation will be kept. Staff education to be completed by 08/29/2025

DIRECTED: By 9/5/25: The home shall develop and implement a new hire checklist to ensure all newly-hired staff persons receive orientation on all topics specified in 2600.65b within 40 scheduled working hours. Documentation of the training and the completed new hire checklists shall be kept in each staff person's record. [redacted] 9/3/25.

DIRECTED: By 9/5/25: The administrator shall ensure staff persons B, C and D have received orientation on all topics specified in 2600.65b. Documentation of the education shall be kept in each staff person's record in accordance with 2600.65i. [redacted] 9/3/25

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *09/05/2025*

Implemented ([redacted] - 10/06/2025)

65c - Ancillary Staff Orientation

10. Requirements

2600.
65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person D, whose first day of work was [redacted]/25, did not have a general orientation to [redacted] specific job functions.

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

administrator to ensure all ancillary staff is properly educated prior to the scheduled shift. Staff in question has

65c - Ancillary Staff Orientation (continued)

completed training related to regulation code 2600.65, training administered by Administrator on 08/06/2025. collect staff signature after completion of each training. Ancillary staff files created and placed in designated area. Files to be reviewed every 3 months to ensure all proper documentation is obtained and updated as needed. All hired staff shall receive employee education, to be completed by 08/28/2025 Administrator created and implemented a new hire check list on 08/28/2025 to be implemented on 08/29/2025. (DIRECTED: Immediately: The administrator shall implement a new hire checklist to ensure all newly-hired ancillary staff persons receive a general orientation to their specific job functions at the time of hire. Documentation of the training and the completed new hire checklists shall be kept in each staff person's record. [redacted]9/3/25).

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *08/29/2025*

Not Implemented [redacted] - 10/06/2025)

65d - Initial Direct Care Training

11. 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

Direct care staff person C, hired on [redacted]25, began providing unsupervised ADL services to residents on 5/28/25; however, direct care staff person C has not successfully completed and passed the Department-approved direct care training course and pass the competency test.

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

administrator to ensure all staff is properly educated prior to first day or on the first day of. Administrator to create yearly training plan to ensure all training to completed upon new hire. Plans to be reviewed every 3 months, required changes will be implemented at that time. All other staff files have been reviewed on 07/30/2025. Staff in question will complete approved direct care training course by 08/28/2025, certification shall be placed in staff file upon receiving cert. Administrator has developed a new hire checklistfand plans to implement it on 07/30/2025. (DIRECTED: Immediately: The new hire checklist shall be implemented to ensure all newly-hired direct care staff persons successfully complete the Department-approved direct care training course and pass of the competency test prior to performing unsupervised ADL services to residents. Documentation of the training and the completed new hire checklists shall be kept in each staff person's record. [redacted]9/3/25). Administrator to ensure to collect staff signature after completion of passing each training. Staff education to be completed by 08/28/2025

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *08/29/2025*

Not Implemented [redacted] - 10/06/2025)

85b - Infestation

12. Requirements

85b - Infestation *(continued)*

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

Description of Violation

At approximately 10:30am, numerous live cockroaches were observed running in the home's kitchen, to include a live cockroach in the drawer to the right of the sink, a live cockroach in the cabinet underneath the drawer to the right of the sink and at least 2 live cockroaches in the lazy susan cabinet to the left of the oven.

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

The owner of the home had maintenance worker come in and steam clean all the furniture and clean out the kitchen cabinets afterwards they sprayed the entire home on 08/25/2025. They repeated the steam cleaning on the bed frames and spray the entire home. Staff and administrator tomonitor daily and let the owner of the building know where sightings occur. A weekly checklist will start 8/28/2025 and continue until there are no more sightings of infestation. All hired staff will participate in staff education related to state regulation code 2600.65i, staff education to take place on 8/29/25. Documentation will be kept

Proposed Overall Completion Date: 09/05/2025

Licensee's Proposed Overall Completion Date: *09/05/2025*

Not Implemented - 10/06/2025)

90b - Staff Communication

13. Requirements

2600.
90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The home does not have a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency. On 7/29/25, the home served 10 residents.

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

walkie talkies have been purchased and placed on every floor allowing for proper communication via staff when on different levels of the home. Equipment was purchased on 08/03/2025. Staff to ensure equipment is charged nightly/batteries are functioning properly. Equipment will be signed out and handed to staff at the start of each scheduled shift to ensure each staff is responsible for designated equipment and properly being implemented properly. All hired staff shall receive employee education related to regulation code 2600.65i , will be completed on the proper usage of said walkie talkies, signature will be obtained at completion by 8/28/2025

Proposed Overall Completion Date: 09/05/2025

Licensee's Proposed Overall Completion Date: *09/05/2025*

Implemented - 10/06/2025)

92 - Windows

14. Requirements

92 - Windows *(continued)*

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At approximately 10:30am, there was no screen present in the open window in the kitchen next to the refrigerator.

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

Screens have been put in place to correct this area of concern. Screens applied to areas of concerns on 07/30/2025. Administer to do daily walk through/window checks starting 07/30/2025 to ensure all necessary requirements per state regulations are met. documentations will be kept. All hired staff t to be completed employee training related to state regulation code 2600.65i by 08/238/2025 (DIRECTED: By 9/10/25: All staff persons shall be educated on regulation 2600.92. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 9/3/25).

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented [redacted] - 10/06/2025)

101f - Bedroom Window

15. Requirements

2600.
101.f. Each bedroom must have a window with direct exposure to natural light.

Description of Violation

The only window in the basement bedroom where 4 residents reside is covered with a piece of wood.

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

board over window in area of concern was immediately removed and replaced with a clear plexiglass glass that allows the natural sunlight to pass through. Upon renting the facility the board was already in place. I never questioned it honestly until it was brought to my attention.Administrator/assigned staff that area, will conduct a daily walk through inspections starting 07/30/2025 to ensure the continuance of proper lighting and care is provided to each resident. documentation will be kept. All hired staff to participate in employee training related to state regulation code 2600.65i completed by 08/28/2025

(DIRECTED: By 9/10/25: All staff persons shall be educated on regulation 2600.101f. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 9/3/25).

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented [redacted] - 10/06/2025)

101j2 - Bedroom Chairs

16. Requirements

2600.

101j2 - Bedroom Chairs *(continued)*

101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

Only 3 chairs were present in the basement bedroom where 4 residents reside.

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

Proper number of required chairs have been placed in area of concern, totaling 4 chairs in area.on 07/29/2025. Administrator/staff to do daily checks starting 07/30/2025 to ensure required supplies/furnitures are in place and at residents access. documentations will be kept, All hired staff to complete staff education related to state regulation code 2600.65i, to ensure staff is aware of all required regulation, training to completed by 08/29/2025

(DIRECTED: By 9/10/25: All staff persons shall be educated on regulation 2600.101j2. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 9/3/25).

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented ([redacted] - 10/06/2025)

101j4 - Bedroom Storage Area

17. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
4. A storage area for clothing that includes a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident.

Description of Violation

Only 1 closet was present in the basement bedroom where 4 residents reside, which is not sufficient to store clothing for all 4 residents.

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

Plan of action has been set forth on this day of 08/04/2025, second closet in area of concern been made accessible to residents. Administrator to ensure adequate space for every resident. Administrator to ensure monthly closet clean outs to eliminate unwanted items, monthly checks are implemented to begin 08/04.2025, assigned scheduled staff to ensure monthly checks are completed for every resident .documentation will be kept. All hired staff to participate in employee training regarding state regulation code 2600.65i, to be completed by 08/29/2025 (DIRECTED: By 9/10/25: All staff persons shall be educated on regulation 2600.101j4. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 9/3/25).

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented [redacted] - 10/06/2025)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

18. Requirements

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface *(continued)*

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

There was no grab bar, hand rail or assist bar present in the shower of the downstairs walk-in shower room.

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

Grab bar was immediately installed on 08/01/2025 to ensure residents safety in area of concern. Daily inspections by administrator/staff to begin on 07/30/2025. to ensure proper functioning and proper placement of all equipment in facility. All hired staff to participate in employee training related to state regulation code 2609.65i. education to be completed by 08/28/2025 (DIRECTED: By 9/10/25: All staff persons shall be educated on regulation 2600.102d. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 9/3/25).

Proposed Overall Completion Date: 09/09/2025

Directed Completion Date: *09/10/2025*

Implemented [redacted] - 10/06/2025)

102h - Toilet Paper

19. Requirements

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

Description of Violation

At 9:49am, there was no toilet paper present in the ground floor common restroom.

At approximately 10:30am, there was no toilet paper present in the 1st floor common restroom.

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

Proper supplies was applied to areas of concerns on 07/29/2025, to ensure necessary supplies/items are available to residents at all times. Resident steal the toilet paper. Each shift to monitor and walk through via administrator/staff to begin on 07/30/2025, will ensure adequate supplies are in place. All hired staff shall participate in training related to state regulation code 2600.65i. to be completed on 08/28/2025 All documentation shall be kept. (DIRECTED: By 9/10/25: All staff persons shall be educated on regulation 2600.102h. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 9/3/25).

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Not Implemented [redacted] - 10/06/2025)

107a - Emergency Preparedness

20. Requirements

2600.

107a - Emergency Preparedness *(continued)*

107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

The home does not have a copy of the emergency preparedness plan for the municipality in which the home is located.

Plan of Correction ***Directed (- 09/03/2025)***

Emergency preparedness plan for the municipality has been printed and placed in designated area on 08/05/2025. Administrator/staff to ensure all required documentation is posted in a general area, monthly checks will be completed to ensure compliance. (DIRECTED: The monthly checks shall begin on 9/10/25. 9/3/25). All hired staff to participate in employee training related to state regulation code 2600.65i, training to be completed on 08/29/2025. All documentation will be kept.

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented - 10/06/2025)

107c - Food/Water 3 Day Supply

21. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 7/29/25, the home served 10 residents, requiring a minimum of 30 gallons of drinking water for a 3-day emergency supply. However, there was only 10 gallons of emergency drinking water available in the home. The home does not have a contract with a local bottled water supplier to provide emergency drinking water in the event of an emergency.

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

On 08/15/2025 an additional 25 gallons of water was purchased, dated, and stored. As more residence move into Graysful living additional water will be purchased on those days and stored dated and placed in the proper area. Administrator to implement a monthly check to verify enough gallons of water to stay in compliance with state regulation code 2600.65i. (DIRECTED: The monthly checks shall begin on 9/10/25 to ensure compliance with 2600.107c, which includes ensuring there is at least 1 gallon of water present in the home for each resident per day for a 3 day supply. 9/3/25). Administrator will ensure if any are used they are replaced immediately - monthly checks on water supply will be done by administrator and documentation will be kept. I hired staff were attend a employee education. employees will sign verifying they attended and completed the training. all documentations will be kept 8/28/2025

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented - 10/06/2025)

123b - Emergency Procedures Posted

22. Requirements

123b - Emergency Procedures Posted *(continued)*

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

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

A copy of emergency preparedness plan was printed and placed in the dining room on 7/31/25. Administrator to ensure all required documentation is up to date and placed in designated area monthly. Initial check was completed on 07/30/2025. Checklist will be completed and documentation will be kept.All hired staff to complete employee education to remain in accordance with state regulation code 2600.65i. Training to be completed on 08/28/2025 all documentation shall be kept.

Licensee's Proposed Overall Completion Date: *09/05/2025*

Implemented [redacted] - 10/06/2025)

130e - Hearing Impairment

23. Requirements

2600.
130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

Resident #1 is unable to hear the fire alarm system; however, resident #1 does not have a signaling device approved by a fire safety expert to ensure resident #1 is alerted in the event of a fire.

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

Administrator spoke to fire department, medical supply store [redacted] and local officials. American Red Cross is trying to expedite a bed shaker for the resident as fast as possible. Administrator will continue communicating with American Red Cross to ensure the shaker comes asap. In the future, Administrator will address these kind of issues when completing a screening. Staff education to take place on 8/28/2025 documentation will be kept

DIRECTED: By 9/10/25: The administrator shall ensure a signaling device approved by a fire safety expert is present on resident #1's bed to ensure resident #1 is alerted to the activation of the home's fire alarm system/smoke detector. If the fire alarm system/smoke detector is activated prior to 9/10/25, a staff person on duty shall immediately notify resident #1 that the fire alarm/smoke detector was activated and provide assistance to resident #1 to evacuate the home. [redacted] 9/3/25

DIRECTED: By 9/10/25: The administrator shall develop and implement new admission procedures to ensure a signaling device approved by a fire safety expert is obtained and installed on the resident's bed at admission for any newly-admitted resident who is unable to hear the fire alarm system/smoke detector. Documentation of the procedures shall be kept. [redacted] 9/3/25

Proposed Overall Completion Date: 09/05/2025

130e - Hearing Impairment *(continued)*

Directed Completion Date: *09/10/2025*

Not Implemented [redacted] 10/06/2025)

141a 1-10 Medical Evaluation Information

24. 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. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluation, dated [redacted] /25, does not include resident #1's weight, pulse rate, blood pressure or temperature. These areas of resident #1's medical evaluation are blank.

Resident #2's medical evaluation, dated [redacted] /25, does not include resident #2's weight, pulse rate, blood pressure or temperature. These areas of resident #2's medical evaluation are blank.

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

Administrator obtained vitals of residents lacking proper documentation, [redacted] was placed in designated areas, as well as initialed by prescribing doctor, to ensure corrections. Administrator to ensure all documentation is completed per state regulations, review of new resident files after 30 days of admission, then annually there after. Documentation will be kept. Staff education to be completed by 08/28/2025

DIRECTED: By 9/10/25: The administrator shall review all current resident records to ensure each resident has a medical evaluation completed in its entirety, including residents #1 and #2. [redacted] 9/3/25

DIRECTED: By 9/10/25: The administrator shall develop and implement a new admission checklist to ensure a medical evaluation is completed in its entirety for each new resident in accordance with 2600.141a. The completed new admission checklists shall be kept in each resident's record. [redacted] 9/3/25

141a 1-10 Medical Evaluation Information (continued)

141a 1-10 Medical Evaluation Information (continued)

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented ([redacted] - 10/06/2025)

162c - Menus Posted

25. 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 only menu posted in a conspicuous and public place in the home ended on 7/18/25.

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

corrections to menu was implemented immediately to ensure acurate dates and meals matching on 7/29/2025. Administrator to ensure menus are updated weekly with the present week, last week, and the following week. Summer menu rotates until fall, fall menu starts in October. All hired staff to receive staff education related to Pa state regulation code 2600.65i, to be completed by 08/28/2025

DIRECTED: Beginning on 9/10/25: The administrator shall inspect the home weekly to ensure compliance with 2600.162c. [redacted] 9/3/25

162c - Menus Posted (continued)

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented [redacted] - 10/06/2025)

185a - Implement Storage Procedures

26. Requirements

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

Description of Violation

Resident #2 is currently prescribed Hydroxyzine HCL 25mg tablet-Take 1 tablet by mouth every 8 hours as needed; however, this medication is not present in the home and available for administration.

Resident #2 is currently prescribed Novolog Flexpen insulin-Inject subcutaneously 3 times daily in accordance with sliding scale coverage. However, resident #2's blood glucose readings were incorrectly documented on resident #2's blood glucose log on numerous occasions, to include the following:

- *On 7/29/25 at 11:23am, resident #2's glucometer indicated a blood glucose reading of 104; however, was documented on resident #2's blood glucose log as 106*
- *On 7/24/25 at 11:57am, resident #2's glucometer indicated a blood glucose reading of 122; however, was documented on resident #2's blood glucose log as 146*
- *On 7/23/25 at 11:54am, resident #2's glucometer indicated a blood glucose reading of 90; however, was documented on resident #2's blood glucose log as 184*
- *On 7/23/25 at 8:05am, resident #2's glucometer indicated a blood glucose reading of 174; however, was documented on resident #2's blood glucose log as 121*

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

Resident #1' medication was delivered on 7/29/2025. Administrator completed a med audit on all residents on 8/15/25. Administrator will do weekly audits until 9/5/25 and then monthly audits. Documentation will be kept. (DIRECTED: The audits shall include a review of all resident medications to ensure all prescribed medications are present in the home and available for administration.[redacted] 9/3/25). Documentation was kept. On 8/29/2025 Administrator will make it mandatory for med trained staff to take picture of the results and send to administrator to provide verification of blood sugars being taken while administrator is not there to ensure they are taken on time and recorded properly. administrator to ensure all documentation/equipment matches to decrease risks of medication errors, to ensure residents safety. Daily checks of blood sugar test results for all residents getting blood sugar testing will be done until 9/5/25 and then weekly afterwards to identify any issues and ensure resident blood sugar is correct and documented correctly. documentation will be kept. all staff will receive education to be completed by 08/29/2025 documentation will be kept.

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *09/10/2025*

185a - Implement Storage Procedures *(continued)*

Not Implemented [redacted] - 10/06/2025)

187b - Date/Time of Medication Admin.

27. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #4's July 2025 medication administration record (MAR) includes an order for Nicotine 14mg patches-Apply 1 patch topically once a day. Staff person A indicated that resident #4 continues to smoke and has not received the nicotine patch during the month of July; however, resident #4's July MAR includes initials from numerous staff persons indicating the patch was applied to resident #4 daily from 7/1/25 through 7/14/25, as well as daily from 7/17/25 through 7/29/25.

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

Full medication/MAR review was done on 8/15/2025. Administrator to audit med cart every two weeks, first audit was completed on 8/15/2025, audits will continue to be implemented every week from here on after, to ensure proper administration/documentation is be utilized, to ensure the safety and health of the residents. (DIRECTED: The audits shall include a review of all resident MAR's during each audit to ensure compliance with 2600.187b. [redacted] 9/3/25). All hired staff will attend employee education, Open sure we stay in compliance with state code 2600.65i. all staff signatures will be collected, verifying they attended and completed this training, to be completed by 08/28/2025 documentation will be kept

DIRECTED: By 9/10/25: The administrator shall re-educate all staff persons qualified to administer medications on proper medication administration documentation procedures on resident MAR's. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 9/3/25

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Not Implemented [redacted] - 10/06/2025)

187d - Follow Prescriber's Orders

28. Requirements

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

Description of Violation

Resident #2 is currently prescribed Novolog Flexpen insulin-Inject subcutaneously 3 times daily in accordance with sliding scale coverage; however, there are no blood glucose readings present on resident #2's glucometer for the following dates/times, so it is unable to be determined if resident #2 should have received the Novolog insulin:

- *On 7/25/25 and 7/27/25 at lunch*
- *On 7/27/25 at dinner*

187d - Follow Prescriber's Orders (continued)

Resident #6 is currently prescribed blood glucose checks twice daily; however, there are no blood glucose readings present on resident #6's glucometer on the evenings of 7/27/25 an 7/28/25.

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

state approved diabetes patient education program has been completed by all staff on 8/13/2025. Administrator will place completion certs. in staff designated file, when received. Administrator to implement a plan of a daily check on all glucose monitors and documented results for all diabetic residents, to provide verification of results/completion of accucheck. (DIRECTED: The daily audits shall begin on 9/5/25.[redacted] 9/3/25). Administrator to monitor daily to ensure all documentations related to issue at hand is correct. Weekly daily check of accuchecks and documentations shall begin on 8/26/2025. All hired staff to attend employee education training program signatures required to verify they completed this training all documentation shall be kept.

DIRECTED: By 9/10/25: The administrator shall re-educate all staff persons qualified to administer medications on proper medication administration procedures, which includes ensuring prescribers orders are followed in accordance with 2600.187d. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 9/3/25

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Not Implemented ([redacted] - 10/06/2025)

190a - Completion Medication Course

29. 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

Direct care staff person C has not successfully completed the Department-approved medications administration course; however, direct care staff person C has administered numerous medications to numerous residents on numerous dates/times, to include the following:

- *Albuterol HFA inhaler to resident #1 on 7/16/25, 7/17/25 and 7/19/25*
- *Levothyroxine-75mg tablet, Lisinopril-10mg tablet and Metformin-1,000mg tablet to resident #2 on 7/3/25 at 8:00am*
- *Amlodipine-10mg tablet, Cyclobenzaprine-5mg tablet and Escitalopram-20mg tablet to resident #4 on 7/3/25 at 8:00am*

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

Administrator was unaware that the Medication administration trainer had given the Medication certifications papers to us. Staff person B and D completed medication training last updated 03/05/2025, documentation will be

190a - Completion Medication Course (continued)

kept with staff files. Our companies train the trainer is Jamie Thompson. Staff person C has not completed the department approved medication course however staff person C has been signed up for the online course to begin.The staff files are updated and staff that is interested has been scheduled to take part in an upcoming department approved medications administration course. Administrator to updated all staff files with certificate verifying the passing of such course on 8/5/2025. Administrator to monitor residents med training certification every 6 months to ensure no lapse in trainings. Documentation will be kept. All hired staff to attend employee education related to state regulatory code 600.190 a, to be completed by 08/29/2025. Administrator to developed and is implementing a staff training checklist to ensure records are complete on 8/29/2025 - documentation will be kept

DIRECTED: By 9/10/25: The administrator shall develop and implement a tracking system which includes the dates each direct care staff persons has successfully completed the Department-approved medication course specified in 2600.190a, as well as the dates all annual practicums have been completed in accordance with the Department-approved medication administration course. The tracking system shall also include the dates each direct care staff person has successfully completed the Department-approved diabetes patient education program in accordance with 2600.190b. Documentation of the tracking system shall be kept. Beginning on 10/1/25, the administrator shall review the tracking system quarterly to ensure compliance with 2600.60a, 2600.190a and 2600.190b. [redacted] 9/3/25

Proposed Overall Completion Date: 08/29/2025

Directed Completion Date: *09/10/2025*

Not Implemented [redacted] - 10/06/2025)

190b - Insulin Injections

30. 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

The home currently does not have any staff persons who have successfully completed the Department-approved diabetes patient education program within the past 12 months. Resident #2 is currently prescribed Novolog Flexpen insulin-Inject subcutaneously 3 times daily in accordance with sliding scale coverage. According to resident #2's July 2025 MAR, staff persons A and C have been administering resident #2's Novolog to the resident daily from 7/1/25 through 7/29/25.

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

state approved diabetes patient education program has been completed by ALL staff on 8/13/2025. Administrator will place completion certs. in staff designated file, when received. Administrator will audit staff files every 6 months to ensure trainings are up to date. Administrator to develop and implement a tracking system that includes current dates of all employees receiving diabetic education as well as the dates of each employee successfully completing medication ministration program and includes an annual practicum. program should begin to be implemented on 08/28/2025. Documentation to be kept. All hired staff participate an employee education related to State

190b - Insulin Injections (continued)

regulation code 2600.190B, education to take place 8/28/25.

DIRECTED: By 9/10/25: The administrator shall develop and implement a tracking system which includes the dates each direct care staff persons has successfully completed the Department-approved medication course specified in 2600.190a, as well as the dates all annual practicums have been completed in accordance with the Department-approved medication administration course. The tracking system shall also include the dates each direct care staff person has successfully completed the Department-approved diabetes patient education program in accordance with 2600.190b. Documentation of the tracking system shall be kept. Beginning on 10/1/25, the administrator shall review the tracking system quarterly to ensure compliance with 2600.60a, 2600.190a and 2600.190b. [redacted] 9/3/25

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Not Implemented ([redacted] - 10/06/2025)

191 - Resident Right to Refuse

31. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #3's record does not include documentation that resident #3 has been educated on the resident's right to question or refuse a medication if the resident believes that there may be a medication error.

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

Proper documentation has been corrected, signed by resident on 07/30/2025, and placed in designated files. Administrator to review resident charts after 30 days of move in and then annually there after to ensure all required documentation are signed and in designated area. Initial current record review for our residence began on 7/30/2025. (DIRECTED: By 9/10/25: The administrator shall review all current resident records to ensure documentation is present in each resident's record in accordance with 2900.191. [redacted] 9/3/25). All documentation [redacted] kept. Are hired staff shower attend employee education training so I'll stay in compliance with state regulation code 2600.65i. Signatures of all employees will be received and all documentation shall be kept, to be completed by 08/28/2025

DIRECTED: By 9/10/25: The administrator shall develop and implement a new admission checklist to ensure compliance with 2600.191. The completed new admission checklists shall be kept in each resident's record.[redacted] 9/3/25

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented [redacted] - 10/06/2025)

221c - Post Activity Calendar

32. Requirements

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

The home did not have a current weekly activity calendar posted in a public and conspicuous place in the home.

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

on 8/1/2025 a monthly activities calendar was created and placed in area open for all to view. Administrator to monitor daily during walk through, initial daily walk-throughs began on 7/30/2025, to verify all documentations are in proper orders and visible to all. All hired staff required to attend employee education training program signatures will be required to verify they completed such trainings. All documentation shall be kept to be completed by 08/28/2025

Licensee's Proposed Overall Completion Date: *09/05/2025*

Implemented [redacted] - 10/06/2025)

225a - Assessment 15 Days

33. Requirements

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

Description of Violation

Resident #2's assessment, dated [redacted]/25, indicates resident #2 is independent with managing finances; however, according to staff person A, the home's administrator, resident #2 has a representative payee who manages resident #2's finances.

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

Resident requires to have a payee to separate [redacted] finances, to provide assistance with [redacted] financial needs to separate [redacted] rent from [redacted] P[redacted]. Resident is independent with managing his P[redacted]. Residence assessment update it on 08/10/2025, to ensure all proper documentation has been completed and to stay in compliance with State regulation code 2600.225. All of the residents assessments were reviewed by administrator starting on 8/10/2025, to ensure accuracy and completeness. All files were completely reviewed on 08/12/2025 all documentation to be kept.

DIRECTED: By 9/10/25: The administrator shall develop and implement a new admission checklist to ensure an assessment is completed in its entirety for each new resident in accordance with 2600.225a. The completed new admission checklists shall be kept in each resident's record. [redacted] 9/3/25

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented [redacted] - 10/06/2025)

227a - Support Plan 30 Days

34. Requirements

2600.

[redacted]

227i - Support Plan Accessible *(continued)*

Description of Violation

Resident support plans are kept in the administrator's office, and are inaccessible to direct care staff persons when the administrator is not present in the home, because the administrator's office is locked.

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

Staff was provided with immediate access to office/resident files. Administrator provided copy of key to staff for accessibility to resident files. Administrator to have key in area that is easily accessible by all staff. Administrator to monitor location of key daily during scheduled daily walk throughs. Staff education to be completed by 08/28/2025

Licensee's Proposed Overall Completion Date: *09/05/2025*

Implemented [redacted] - 10/06/2025)

251b - Record Entries Legible

36. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on section 2 of the Rent Rebate Addendum to resident #3's resident-home contract, dated 7/17/25.

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

Administrator immediately corrected this issue by removing unlegible documentations, replacing them with proper documentation and resigned by resident on 07/30/2025. Oh resident files reviewed on 07/30/2025. Administrator to review resident files after 30 days of admission to insure all documentation is signed, dated, and in designated area. (DIRECTED: The review of resident files after admission shall begin on 9/5/25. [redacted] 9/3/25). Administrator to review resident files every 6 months there after to verify proper/legal documentation is in place. All hired staff to participate in employee education relating to state regulation code 2600.65i, Staff education to be completed on 08/29/2025. Documentation will be kept

DIRECTED: By 9/10/25: The administrator shall educate all current staff persons that correction fluid is not permitted on resident records. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/3/25

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented [redacted] - 10/06/2025)

252 - Record Content

37. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #3's record does not include a photograph of the resident.

252 - Record Content (continued)

Resident #4's record does not include a photograph of the resident.

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

Pictures of residents was immediately taken, printed, and placed in designated area. Administrator to take photo on day of contract signing, print, and place in designated file. (DIRECTED: The process of taking resident photographs on the day the contract is completed shall begin on 9/5/25. [redacted]9/3/25). Administrator to review resident files 30 days after move in date, to ensure all proper documentation are in place. (DIRECTED: The monthly audit of all resident files shall begin on 9/10/25 to ensure a photograph of each resident that is no older than 2 years old is present in each resident record.[redacted] 9/3/25). Initial file review was completed on 07/30/2025. will review resident files every 6 months thereafter. All hired staff to participate in employee education regarding state regulation code 2600.65i, staff education to be completed by 08/29/2025. What documentation shall be kept

Proposed Overall Completion Date: 09/05/2025

Directed Completion Date: *09/10/2025*

Implemented [redacted] - 10/06/2025)