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

October 23, 2025

LEGAL ENTITY
EC OPCO SC LLC

RE: CELEBRATION VILLA OF NITTANY VALLEY
150 FARMSTEAD LANE
STATE COLLEGE, PA, 16803
LICENSE/COC#: 23374

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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: *CELEBRATION VILLA OF NITTANY VALLEY* **License #**: *23374* **License Expiration**: *07/03/2026*

Address: *150 FARMSTEAD LANE, STATE COLLEGE, PA 16803*

County: *CENTRE* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *EC OPCO SC LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/02/2010* **Issued By**: *Center County Region*

Staffing Hours

Resident Support Staff: *41* **Total Daily Staff**: *99* **Waking Staff**: *74*

Inspection Information

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

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

Inspection Dates and Department Representative

07/30/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *37*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *20* **Residents Served**: *17*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *54*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *21* **Have Physical Disability**: *0*

Inspections / Reviews

07/30/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/05/2025*

09/09/2025 - POC Submission

Submitted By: **Date Submitted**: *09/24/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/16/2025*

Inspections / Reviews *(continued)*

09/17/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *09/24/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date**: *09/27/2025*

10/21/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *09/24/2025*
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

At 9:39 a.m., a resident care log with resident information was sitting on a dining room table in the memory care unit.
A
At 11:52 a.m., a binder with resident care information was found on top of a microwave in the memory care kitchenet.
At approximately 11:55 a.m., the medication room door in the memory care unit was open with a computer screen open exposing resident information.

Plan of Correction ***Accept (█ - 09/08/2025)***

ACTION: On July 30, 2025, the Executive Director and Memory Care Coordinator completed a walkthrough of both the Personal Care Unit and Memory Care Unit. All binders, folders, and logs containing Resident Care information were removed by the Executive Director and Memory Care Coordinator and placed in a secured area. On July 30, 2025, the Executive Director and Memory Care Coordinator ensured that all Medication Room doors checked for proper closer and locking mechanisms for compliance with Regulation 2600.17.

TRAINING: On July 30, 2025, the Regional Director of Clinical Operations educated the Executive Director on Regulation 2600.17. On August 1, 2025, the Executive Director educated the Leadership Team (Director of Sales and Marketing, Director of Maintenance, Life Enrichment Director, Director of Culinary Excellence, and Administrative Assistant on Regulation 2600.17. On August 4, 2025, the Executive Director educated the Director of Nursing, Memory Care Coordinator, and Resident Care Coordinator on Regulation 2600.17. Between August 19, 2025, and August 21, 2025, the Executive Director and Director of Nursing educated all staff, during the staff meeting, on Regulation 17.2600. Training records will be kept in accordance with Regulation 2600.65i.

ONGOING: Effective, July 30, 2025, the Resident Care Coordinator and Memory Care Coordinator will complete audits by completing check lists and walkthroughs of the units at least twice a day to ensure all doors to the Medication Rooms are properly closed and locked, as well as any documents containing Resident information are properly stored, the audits will be completed on the weekends by the Manger on Duty. Documentation will be kept. The overview of findings will be discussed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting, starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

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 [redacted] for resident #2 was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 09/08/2025)***

ACTION: On July 31, 2025, the Executive Director completed an audit on all the current Resident Files within the home to ensure proper signatures were obtained for compliance of Regulation 2600.25.b. Resident # 2's contract will be signed by [redacted] upon receipt of Power of Attorney paperwork. The Resident is unable to sign due to cognitive status. The Resident's [redacted] the current Power of Attorney is unable to sign due to [redacted]. This will be documented on Resident # 2's medical record by the Executive Director on September 2, 2025.

TRAINING: On July 31. 2025, the Regional Director of Operations provided education to the Executive Director on Regulation 2600.25.b. On August 1, 2025, the Executive Director educated the Administrative Assistant and Director of Sales and Marketing on Regulation 2600.25.b. Training records will be kept in accordance with Regulation 2600.65i.

ONGOING: Effective, July 31, 2025, the Executive Director completed an audit on all current contracts for proper signatures to ensure compliance with Regulation 2600.25.b. The Executive Director will continue to monitor all new contracts to ensure proper compliance. Documentation to be kept. The overview of the findings will be discussed by the Leadership Team weekly for 4 weeks then monthly at the Quality Assurance Meeting, starting September 15, 2025. Quality Assurance meeting documentation will be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 10/21/2025)

28a - Refunds

3. Requirements

2600.
28.a. If, after the home gives notice of discharge or transfer in accordance with § 2600.228(b) (relating to notification of termination), and the resident moves out of the home before the 30 days are over, the home shall give the resident a refund equal to the previously paid charges for rent and personal care services for the remainder of the 30-day time period. The refund shall be issued within 30-days of discharge or transfer. The resident's personal needs allowance shall be refunded within 2 business days of discharge or transfer.

Description of Violation

On [redacted] resident #1 was discharged [redacted] and their room was cleaned out on [redacted] On [redacted] a payment of $8655.00 was made for the month of [redacted] bringing Resident #1's balance to $9718.88. The resident was entitled to a refund in the amount of $8382.01 but received a refund in the amount of $496.78 on [redacted]

Plan of Correction ***Accept ([redacted] - 09/08/2025)***

ACTION: On July 31, 2025, the Executive Director met with the Regional Accounts Receivable Specialist to review the information regarding Resident # 1's refund as well as to ensure future compliance with Regulation 2600.28.a. Refund to be requested on 09/05/2025 by the Executive Director.

TRAINING: On July 31, 2025, the Regional Director of Operations educated the Executive Director on Regulation 2600.28.a. On August 4, the Executive Director educated the Administrative Assistant on Regulation 2600.28.a. Training records to be kept in accordance with Regulation 2600.65i.

28a - Refunds (continued)

ONGOING: Effective July 31, 2025, the Administrative Assistant will audit all refunds via spreadsheet to ensure compliance with Regulation 2600.28.a. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting, starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 10/21/2025)

41e - Signed Statement

4. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept (- 09/08/2025)***

ACTION: On July 31, 2025, the Executive Director completed an audit on all the current Resident Files within the home to ensure proper acknowledgement of Resident Rights and Complaint Procedures for Compliance of Regulation 2600.41.e. Resident # 2's statement will be signed by upon receipt of Power of Attorney paperwork. The Resident is unable to sign due to cognitive status. The Resident's the current Power of Attorney is unable to sign due to . This will be documented on Resident # 2's medical record by the Executive Director on September 2, 2025.

TRAINING: On July 31. 2025, the Regional Director of Operations education to the Executive Director on Regulation 2600.41.e. On August 1, 2025, the Executive Director educated the Administrative Assistant and Director of Sales and Marketing on Regulation 2600.65i.

ONGOING: Effective, July 31, 2025, the Executive Director will audit all new contracts for proper acknowledgement of Resident Rights and Complaint Procedures to ensure compliance with Regulation 2600.41.e. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting, starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 10/21/2025)

65g - Annual Training Content

5. Requirements

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

65g - Annual Training Content *(continued)*

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.

Description of Violation

Staff member A and B did not receive training in Fire safety by a fire safety expert or staff trained by a fire safety expert for the 2024 training year.

Plan of Correction ***Accept (- 09/17/2025)***

ACTION: On July 31, 2025, the Executive Director and Director of Maintenance reviewed the sign in sheet for the Fire Safety Training for compliance of Regulation 2600.65.g. The Director of Maintenance and Staff Member B were noted to be with the Fire Safety Expert in the Community at the time of the Training. Staff Member A is no longer employed in the Community. A letter has been requested on 09/10/2025 and on 09/15/2025 from the Fire Safety Expert indicating the presence of Staff Member B during the initial training.

TRAINING: On July 31, 2025, the Regional Director of Operations educated the Executive Director or Regulation 2600.65.g. On July 31, 2025, the Executive Director educated the Director of Nursing and the Director of Maintenance on Regulation 2600.65.g. Training records will be kept in accordance with Regulation 2600.65i.

ONGOING: Effective, August 1, 2025, the Director of Maintenance will audit and keep record of all all Fire Drill Logs / Sign in Sheets to ensure all signatures, including the Director of Maintenance, are captured for those in attendance to ensure compliance with Regulation 2600.65.g. The Executive Director will monitor the training plan and attendees monthly for 2025 starting September 1, 2025. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 10/21/2025)

66a - Staff Training Plan

6. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for the 2025 training year. Staff training plan provided was the plan with a different home's name on it.

Plan of Correction ***Accept (- 09/08/2025)***

ACTION: On July 31, 2025, the Executive Director reviewed the 2025 Plan with the Regional Director of Operations and the Senior Director of Organizational Learning and Development for compliance of Regulation 2600.66.a. The Senior Director of Organizational Learning and Development was able to review. Updated plan received from Senior Director of Organizational Learning and Development on August 6, 2025, and added to State Binder.

TRAINING: On July 31, 2025, the Regional Director of Operations educated the Executive Director on Regulation

66a - Staff Training Plan (continued)

2600.66.a. Training records will be kept in accordance with Regulation 2600.66.a.

ONGOING: Effective July 31, 2025, the Executive Director will audit all necessary paperwork to ensure the proper name is listed to ensure compliance with Regulation 2600.66.a. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

81b - Resident Personal Equipment

7. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

At 9:51 a.m., an oxygen tank was unsecured and stored directly on the floor in resident room 215.
At 11:50 a.m., Two (2) oxygen tanks were sitting directly on the floor unsecured in the clothing storage area of resident room 310.

Plan of Correction ***Accept (█ - 09/08/2025)***

ACTION: On July 31, 2025, the Executive Director and Director of Maintenance purchased wooden crates for proper storage and security of Oxygen Tanks to ensure compliance with Regulation 2600.81.b. On August 1, 2025, Oxygen Tanks for Rooms 215 and 310 were checked and separated by the Executive Director. The Director of Maintenance obtained wooden crates and placed the tanks in their respected crates. The oxygen tanks in Room 310 were removed by the Durable Medical Company on August 10, 2025, due to discontinuation of order by Physician.

TRAINING: On July 31, 2025, the Regional Director of Clinical Services educated the Executive Director on Regulation 2600.81.b. On August 1, 2025, the Executive Director educated the Director of Maintenance, Resident Care Coordinator, and Memory Care Coordinator on Regulation 2600.81.b. On August 4, 2025, the Executive Director educated the Director of Nursing on Regulation 2600.81.b. Between August 19, 2025, and August 21, 2025, the Executive Director and Director of Nursing educated all staff, during their staff meeting, on Regulation 2600.81.b. Training records to be kept in accordance with Regulation 2600.66.a

ONGOING: Effective August 1, 2025, the Director of Maintenance will monitor and complete an audit three times a week on the Resident Rooms with Oxygen Tanks via spread sheet to ensure compliance with Regulation 2600.81.b. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

82a - Poisonous Materials

8. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

At approximately 9:38 a.m., under the memory care kitchenette sink a bottle labeled Viking Pure Disinfectant had a label that was crossed out and the word cleanser was written in black marker on the label.

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

ACTION: On July 31, 2025, the Director of Maintenance performed an audit on all the cleaning bottles within the Community for proper labeling to ensure compliance with Regulation 2600.82.a. All mislabeled bottles were destroyed immediately and replaced with properly labeled bottles. All mislabeled bottles were removed by the Director of Maintenance on 07/31/2025, they were properly destroyed and replaced with appropriately labeled bottles.

TRAINING: On July 31, 2025, the Regional Director of Operations educated the Executive Director on Regulation 2600.82.a. On August 1, 2025, the Executive Director educated the Director of Maintenance and the Director of Culinary Experience on Regulation 2600.82.a. On August 1, 2025, the Director of Maintenance and the Director of Culinary Experience educated their staff on Regulation 2600.82.a. Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 1, 2025, the Director of Maintenance will complete three audits weekly to ensure compliance with Regulation 2600.82.a. All findings will be documented accordingly on a spreadsheet. Any mislabeled items will be destroyed immediately. Audits will be monitored by the Director of Maintenance and Executive Director. Findings will be reviewed by the Leadership Team weekly for 4 weeks then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder the Executive Directors Office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 10/21/2025)

82c - Locking Poisonous Materials

9. 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

At approximately 11:39 a.m., a tube of Renew Skin Repair cream, and a box of denture cleaner, with manufacturer's label indicating " in case of accidental ingestion seek physician or Poison Control" was unlocked, unattended, and accessible to residents of the secure dementia unit. All the residents of the secure dementia care unit have been assessed as incapable of recognizing and using poisons safely.

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

ACTION: On July 30, 2025, upon immediate notification of the inspection findings, the Memory Care Coordinator completed a walkthrough of the Memory Care Unit to ensure poisonous materials are locked and inaccessible to residents for resident safety and to ensure compliance with Regulation 2600.82.c. The Director of Maintenance completed a walkthrough of the remainder of the Community on July 31st, to ensure all poisonous materials were stored properly.

82c - Locking Poisonous Materials (continued)

TRAINING: On July 31, 2025, the Regional Director of Clinical Operations educated the Executive Director on Regulation 2600.82.c. On July 31, 2025, the Executive Director educated the Memory Care Coordinator and Resident Care Coordinator on Regulation 2600.82.c. On August 4, 2025, the Executive Director educated the Director of Nursing on Regulation 2600.82.c. Between August 19, 2025, and August 21, 2025, the Executive Director and Director of Nursing educated all staff during their staff meetings on Regulation 2600.82.c. Training records will be kept in accordance with Regulation 2600.65i.

ONGOING: Effective July 31, 2025, the Memory Care Coordinator will audit the Resident Rooms located within the Secured Dementia Unit daily, by completing walkthroughs and recording any and all findings on the designated spreadsheet. Any poisonous materials found within the Memory Care Unit will be destroyed immediately and notification will be made to the Executive Director to ensure compliance with Regulation 2600.82.c. The remainder of the Community will have daily walkthrough audits completed as well by the Resident Care Coordinator; all findings will be documented on designated spreadsheet. The Manager on Duty will complete these audits on the weekend days, via walk through with documentation to be made on the designated spread sheet. Reminders will be sent to all Families on September 5th by the Executive Director regarding proper storage of poisonous materials. All audits will be monitored by the Memory Care Coordinator, Resident Care Coordinator and the Executive Director Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

85b - Infestation

10. Requirements

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

Description of Violation

At approximately 9:40 a.m., an active hornet's nest was above the therapy patio exit door.

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

ACTION: On July 30, 2025, immediately upon finding the active hornet's nest above the therapy patio exit door, the Director of Maintenace successfully removed the nest to ensure compliance with Regulation 2600.85.b. On July 30, 2025, the Director of Maintenance performed an inspection to the entire external location of the building, all exit doors and patios were checked to ensure no nests were present.

TRAINING: On July 31, 2025, the Regional Director of Operations educated the Executive Director on Regulation 2600.85.b. On July 31, 2025, the Executive Director educated the Director of Maintenance on Regulation 2600.85.b. Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective July 31, 2025, the Director of Maintenance will perform a daily audit on the exterior of the building, this will be completed during all seasons in which hornets nests are likely for form. The Manager on duty will be responsible for completing these rounds on their designated weekends. If the Director of Maintenance is unable to complete these rounds, the Executive Director will assume responsibility for completion to ensure compliance with Regulation 2600.85.b. Documentation will be kept and reviewed by the Leadership Team weekly

85b - Infestation (continued)

for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

88a - Surfaces

11. 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

At approximately 9:44 a.m., the laundry room's washer/dryer outlet was pulled away from the wall exposing electrical wires.

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

ACTION: On July 30, 2025. Upon finding the outlet being pulled away from the wall, the Laundry Room was put Out of Service but the Director of Maintenance. On July 31, 2025, the Director of Maintenance repaired the outlet to ensure compliance with Regulation 2600.88.a. On July 31, 2025, the Director of Maintenance also completed inspection of all outlets within the community Laundry Areas to ensure no others were pulled away from the wall.

TRAINING: On July 31, 2025, the Regional Director of Operations educated the Executive Director on Regulation 2600.88.a. On July 31, 2025, the Executive Director educated the Director of Maintenance on Regulation 2600.88.a. Between August 19, 2025 and August 21, 2025, the Executive Director and Director of Maintenance educated all staff during their staff meetings on Regulation 2600.88.a. Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 1, 2025, the Director of Maintenance will perform audits in all Laundry Rooms 3 times a week to ensure compliance with Regulation 2600.88.a. All findings will be recorded on the respected spread sheet and monitored by the Director of Maintenance and Executive Director. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Director's office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

102h - Toilet Paper

12. Requirements

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

Description of Violation

At approximately 9:05 a.m., there was no toilet paper for the toilet in the activities room shared bathroom.

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

ACTION: On July 30, 2025, immediately upon notification of the missing toilet paper noted above, the Director of

102h - Toilet Paper (continued)

Maintenance replenished the holder with the maximum number of rolls allotted to be in compliance with Regulation 2600.102.h.

TRAINING: On July 31, 2025, the Regional Director of Operations educated the Executive Director on Regulation 200.102.h. On July 31, 2025, the Executive Director educated the Director of Maintenance on Regulation 2600.102.h. Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 1, 2025, all new housekeeping staff will be educated on Regulation 2600.102.h. An audit will be done by either the Director of Maintenance or a member of the housekeeping staff to ensure compliance with Regulation 2600.102.h. The Director of Maintenance and Executive Director will monitor the audit. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

103e - Left Overs

13. Requirements

2600.
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

At approximately 2:47p.m., a large tube of Hamburger was not labeled or dated in the home's freezer.

Repeat Violation: 9/10/24.

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

ACTION: On July 30, 2025, immediately upon finding the tube of hamburger meat in the freezer, the Director of Culinary Experience disposed of the meat due to not being labeled or date to ensure compliance with Regulation 2600.103.e. The Director of Culinary Experience also completed a full check of all items in the kitchen on July 30, 2025, any items open and not properly labeled or dated were disposed accordingly. Outcome of the full audit completed on July 30, 2025, was reflected on designated audit spread sheet.

TRAINING: On July 31, 2025, the Regional Director of Operations educated the Executive Director on Regulation 2600.103.e. The Executive Director reeducated the Director of Culinary Excellence on Regulation 2600.103.e. On August 4, 2025, the Executive Director and Director of Culinary Excellence educated all the Dietary Staff on Regulation 2600.103.e. Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 1, 2025, the Director of Culinary Excellence will audit the refrigerators and freezers three times a week for undated / unlabeled food. A new sign will be posted as a reminder in the kitchen to label items removed from their original packaging. The audit findings will be recorded on a spread sheet and monitored by the Director of Culinary Excellence and Executive Director. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Director's office.

103e - Left Overs *(continued)*

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

103i - Outdated Food

14. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At approximately 9:50a.m, a four pack of vanilla pudding Snack packs stored in a cabinet in the Hall 2 Dinette had an expiration date of June 25, 2025.

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

ACTION: On July 30, 2025, immediately upon finding the expired vanilla pudding in a cabinet in hall 2 dinette, the Life Enrichment Director disposed of the pudding. The Life Enrichment Director completed an audit on July 31, 2025, of all kitchenette cabinets and refrudgerators to ensure proper labeling and dating of items. All findings were reflected on an appropriate audit spread sheet.

TRAINING: On July 31, 2025, the Regional Director of Operations educated the Executive Director on Regulation 2600.103.I. The Executive Director educated the Life Enrichment Director and Director of Culinary Excellence on Regulation 2600.103.I. Training records kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 1, 2025, the Life Enrichment Director and Director of Culinary Excellence will complete audits three times a week on the cabinets and refrigerators in the dinettes of each hall to ensure compliance of Regulation 2600.103.I. The audit findings will be added to a spreadsheet and monitored by the Life Enrichment Director and/or the Executive Director. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

107c - Food/Water 3 Day Supply

15. 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

There are 150 gallons of emergency drinking water on hand in the home. There are currently 59 residents, which requires 177 gallons to be available.

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

ACTION: On July 31, 2025, the Executive Director and Director of Maintenance calculated the number of gallons required for the number of Residents currently in house, according to Regulation 2600.107.c. The number of gallons required for the current number of Residents (54) is 162 gallons, the additional supplies was delivred on July 31, 2025 to ensure compliance with Regulation 2600.107.c.

107c - Food/Water 3 Day Supply (continued)

TRAINING: On July 31, 2025, the Regional Director of Operations educated the Executive Director on Regulation 2600.107.c. On July 31, 2025, the Executive Director educated the Director of Maintenance on Regulation 2600.107.c. Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 1, 2025, the Director of Maintenance will complete a monthly audit on the amount of emergency drinking water on hand once a week and will ensure compliance with Regulation 2600.107.c. All findings will be documented on a spreadsheet and monitored by the Director of Maintenance and Executive Director. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 10/21/2025)

141b1 - Annual Medical Evaluation

16. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #5's most recent medical evaluation was completed on The medical evaluation does not indicate if the resident is able to self-administer medications.

Plan of Correction ***Accept (- 09/17/2025)***

ACTION: On August 4, 2025, the Executive Director and Director of Nursing completed an audit on all current charts with the Residents in house to ensure compliance with Regulation 2600.141.b. Audit findings were documented on respoected spreadsheet. The Medical Evaluation for Resident # 5 was reviewed by the Director of Nursing with the Medical Director and updated accordingly on August 7, 2025.

TRAINING: On July 31, 2025, the Regional Director of Clinical Services educated the Executive Director on Regulation 2600.141.b. On August 4, 2025, the Executive Director educated the Director of Nursing on Regulation 2600.141.b. Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 1, 2025 through December 1, 2025, the Director of Nursing and the Executive Director will audit all Medical Evaluations completed for current Residents, and findings will be documented on a spread sheet. All Medical Evaluations for current and new Residents completed after August 1st will be checked and initialed by the Director of Nursing and Executive Director, then added to the respective spread sheet to ensure compliance with Regulation 2600.141.b. The audits will be monitored by the Executive Director and Director of Nursing. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Director's ofice.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 10/21/2025)

161d - Dietary Needs

17. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

Resident #2 is not prescribed a mechanically soft diet. On 7/30/25, a posting in the kitchen alerts cooks that the resident is on a mechanically soft diet. There is not a doctor's order for the mechanical soft diet.

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

ACTION: On August 4, 2025, the Executive Director and Director of Nursing reviewed the diets of current Residents to ensure compliance with Regulation 2600.161. d. On July 31, 2025, an order was requested from the Medical Director for Resident # 2 to be on a Medically Soft Diet. An updated order was received on August 1, 2025, and Resident # 2's information was updated accordingly.

TRAINING: On July 31, 2025, the Regional Director of Clinical Services educated the Executive Director on Regulation 2600.161.d. On July 31, 2025, the Executive Director educated the Director of Culinary Experience on Regulation 2600.161.d. On August 4, 2025, the Executive Director educated the Director of Nursing or Regulation 2600.161.d. Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 1, 2025, the Director of Nursing and Director of Culinary Experience will audit the diets for both current Residents and any new Residents to ensure compliance with Regulation 2600.161.d. The audit will be completed bi-weekly and documented accordingly on the respected audit sheet, once the diet is reviewed, the Director of Nursing along with the Director of Culinary Excellence will initial both the diet slip and the audit to ensure compliance. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Director's office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

183f - Discontinued Medications

18. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

Diphen/Atrop 2.5 mg prescribed for Resident #6 was discontinued on 7/18/25 but still in the medication cart.

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

ACTION: On July 30, 2025, the Executive Director and Resident Care Coordinator removed the Medication from the cart immediately after the finding of Resident #6 Diphen/Atrop 2.5 mg.to ensure compliance with Regulation 2600.183.f. On July 31, 2025, the Resident Care Coordinator completed an audit on each Medication Cart to ensure no further discontinued Medications were found.

183f - Discontinued Medications (continued)

TRAINING: On July 31, 2025, the Regional Director of Clinical Services educated the Executive Director on Regulation 2600.183.f. On July 31, 2025, the Executive Director educated the Resident Care Coordinator and Memory Care Coordinator on Regulation 2600.183.f. On August 4, 2025, the Executive Director educated the Director of Nursing and Certified Medication Technicians on Regulation 2600.183.f. Documentation will be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 1, 2025, the Resident Care Coordinator and Memory Care Coordinator will audit the Medication Carts weekly to ensure compliance with Regulation 2600.183.f. This will be monitored by the Director of Nursing by reviewing the respected audit sheets. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Director's office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

187d - Follow Prescriber's Orders

19. Requirements

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

Description of Violation

Resident 7's is prescribed Midodrine Tab 10 MG daily with parameter to hold if systolic blood pressure is over 150. Resident 7 was administered the medication on 7/3/25, at 9:00 a.m. with a systolic blood pressure reading of 154, on 7/10/25, at 1:00 p.m. with a systolic blood pressure reading of 153, and on 7/11/25, at 8 p.m. with a systolic blood pressure reading of 156.

Repeat Violation: 9/10/2024.

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

ACTION: On August 4, 2025, the Director of Nursing performed an audit on all Resident Medication Administration Records for those with parameters on Medications to ensure compliance with Regulation 2600.187.d.

TRAINING: On July 31, 2025, the Regional Director of Clinical Services educated the Executive Director on Regulation 2600.187.d. On August 4, 2025, the Executive Director educated the Director of Nursing and Medication Technicians on Regulation 2600.187.d. Training records kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 4, 2025, the Director of Nursing will complete weekly audits on the Medication Administration Records of Residents who take Medications that require parameters. This will be montiored by the Director of Nursing starting August 4, 2025. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

187d - Follow Prescriber's Orders *(continued)*

191 - Resident Right to Refuse

20. 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 #2 admitted to the home on [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

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

ACTION: On July 31, 2025, the Executive Director completed an audit on all the current Resident Files within the home to ensure proper education of a Residents Right to Refuse Medication to ensure compliance with Regulation 2600. 191.. Resident # 2's education on the Right to Refuse Medication will be signed by [redacted] upon receipt of updated Power of Attorney Paperwork. The Resident cannot sign due to cognition and [redacted], the current Power of Attorney is unable to sign due to [redacted].

TRAINING: On July 31. 2025, the Regional Director of Clinical Services educated the Executive Director on Regulation 2600.191. On August 1, 2025, the Executive Director educated the Administrative Assistant 2600.191. Record of training will be kept in accordance with Regulation 2600.65i.

ONGOING: Effective, July 31, 2025, the Executive Director will audit all new contracts for proper education acknowledgement for their Right to Refuse Medication to ensure compliance with Regulation 2600.191. All findings will be documented on the respective spread sheet. All new Residents after July 31st will be added to the spread sheet and verified that the resident received by both the Executive Director and Administrative Assistant. The audit will be monitored by the Executive Director and Director of Nursing by reviewing the respected audit spreadsheets. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting, starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 10/21/2025)

225a - Assessment 15 Days

21. 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 #1's assessment was completed on [redacted] and not within 15 days of their date of admission on [redacted]

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

ACTION: On August 4, 2025, the Director of Nursing reviewed all the Assessments for the current Residents in the Community to ensure compliance with Regulation 2600.225.a.

225a - Assessment 15 Days (continued)

TRAINING: On July 31, 2025, the Regional Director of Clinical Services educated the Executive Director on Regulation 2600.225.a. On August 4, 2025, the Executive Director educated the Director of Nursing and the Director of Sales and Marketing on Regulation 2600.225.a. Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 4, 2025, the Director of Nursing will ensure compliance with Regulation 2600.225.a. by reviewing the Initial Assessment to ensure it is completed within 15 days of admission. All new Residents moving into the Community will have their assessment initialed by both the Executive Director and Director of Nursing. All new move ins will also be added to the respective spreadsheet and monitored by the Executive Director weekly. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting, starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 10/21/2025)

227g -Support Plan Signatures

22. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2 participated in the development of their support plan dated but was not signed by the resident or indicate that they refused or were unable to sign.

Repeat Violation: 2/5/25.

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

ACTION: On August 4, 2025, the Executive Director and Director of Nursing reviewed all the Support Plans for the current Residents to ensure compliance with Regulation 2600.227.g. The support plan for Resident # 2 will be signed by upon receiving updating Power of Attorney Paperwork. The Resident is unable to sign due to cognition, and the original Power of Attorney is unable to sign due to

TRAINING: On July 31, 2025, the Regional Director of Clinical Services educated the Executive Director on Regulation 2600.227.g. On August 4, 2025, the Executive Director educated the Director of Nursing on Regulation 2600.227.g. Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 4, 2025, the Executive Director and Director of Nursing will verify proper acknowledgement on the Resident Support Plans to ensure compliance with Regulation 2600.227.g. All current and new Residents will be added to the respective spreadsheet and monitored by the Executive Director and Director of Nursing weekly. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting, starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 10/21/2025)

233c - Key-Locking Devices

23. 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

At 9:38 a.m., the directions for operating the home's locking mechanism to the Memory Care courtyard fence exit were illegible.

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

ACTION: On July 30, 2025, the Director of Maintenance replaced the directions for operating the homes locking mechanism for the Memory Care Courtyard Fence immediately upon the finding above to ensure compliance with Regulation 2600.233.c. On July 31, 2025, the Director of Maintenance checked all other directions for locking mechanisms to ensure legibility.

TRAINING: On July 30, 2025, the Regional Director of Operations educated the Executive Director on Regulation 2600.233.c. On July 31, the Executive Director educated the Director of Maintenance and Memory Care Coordinator on Regulation 2600.233.c. Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 1, 2025, the Memory Care Coordinator will check the legibility of the directions to operate the outside locking mechanism three times a week in the Memory Care Courtyard fence to ensure compliance with Regulation 2600.233.c. All audits will be documented accordingly on the respecttive spread sheet and montiored by the Director of Maintenance and Executive Director weekly. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting, starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (█ - 10/21/2025)

252 - Record Content

24. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
   2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

Resident #5's record does not include hair color, eye color, or identifiable marks.

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

ACTION: On July 31, 2025, the Executive Director performed an audit on the records of all the current Residents to ensure compliance with Regulation 2600.252. The records for Resident # 2 were updated accordingly on August 1, 2025 by the Executive Director. All other Resident Records were reviewed and updated by the Executive Director on August 13, 2025.

TRAINING: On July 31, 2025, the Regional Director of Operations educated the Executive Director on Regulation 2600.252. On July 31, 2025, the Executive Director educated the Administrative Assistant on Regulation 2600.252.

252 - Record Content (continued)

Training records to be kept in accordance with Regulation 2600.65i.

ONGOING: Effective August 1, 2025, the Administrative Assistant will audit the Resident Records for all new move ins to ensure compliance with Regulation 2600.252. All Residents will be placed on the respective spreadsheet and monitored by the Executive Director weekly. Documentation will be kept and reviewed by the Leadership Team weekly for 4 weeks, then monthly at the Quality Assurance Meeting, starting September 15, 2025. Quality Assurance meeting documentation to be kept in the designated binder in the Executive Directors office.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 10/21/2025)