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

September 16, 2025

[redacted]
MANOR PERSONAL CARE INC
[redacted]

RE: TABOR MANOR
6730 TABOR AVENUE
PHILADELPHIA, PA, 19111
LICENSE/COC#: 11698

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/31/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *TABOR MANOR* **License #**: *11698* **License Expiration**: *11/30/2025*

Address: *6730 TABOR AVENUE, PHILADELPHIA, PA 19111*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *MANOR PERSONAL CARE INC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *12/01/1971* **Issued By**: *City of Phila. L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *49* **Waking Staff**: *37*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *07/31/2025*

Inspection Dates and Department Representative

07/31/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *51* **Residents Served**: *49*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *34* **Are 60 Years of Age or Older**: *31*

Diagnosed with Mental Illness: *49* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

07/31/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/25/2025*

08/29/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/15/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/05/2025*

Inspections / Reviews *(continued)*

09/11/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/15/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *09/15/2025*

09/16/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/15/2025*

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

16c - Written Incident Report

1. Requirements

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

Description of Violation

On or around [redacted] the home contacted the police due to a former resident appearing at the home and refusing to leave. The police arrived and the former resident fled. The home did not report this incident to the department.

Plan of Correction ***Accept [redacted] - 08/29/2025)***

The home did not initially report the event to the department due to uncertainty about whether the incident qualified as reportable, considering the individual was no longer a current resident. A report was ultimately filed late once clarification was obtained. No harm or Physical altercation occurred.

on 8/6/2025, A late report was submitted to the department as soon as staff realized the incident met reportable criteria.
Internal review was conducted to understand the gap in knowledge and protocol that led to the delay.
8/6/2025 Policies review regarding incident reporting was reviewed with staff to explicitly state that any event involving police response or safety concerns—regardless of whether the individual is a current, former, or prospective resident—must be reported to the department without delay, were reviewed with all staff. Updated policy documents included examples of reportable incidents, including scenarios involving non-residents, former residents, visitors, and others present at the facility.

Training completion will be documented and refresher sessions scheduled annually and upon hire.

The owner and administrator has provide a clear step-by-step protocol for reporting incidents to all staff.
This protocol included:
• Immediate verbal notification to supervisors or designated compliance officer
internal incident report with clear details of the incident, ie time, date , occurance and all involved parties
• Written incident documentation within 24 hours
• Submission of report to the department as required by regulation
• Follow-up communication to ensure receipt and understanding
Location of Emergency contact lists, including department reporting lines.
Beginning 9/15/2025, monthly audits will be conducted by supervisor and administrator to review incident reports for timeliness, completeness, and accuracy.

The facility's administrator will immediately assume responsibility for ensuring that all incident reporting is completed in accordance with regulation 2600.
Quarterly compliance meetings will be held to review incident reporting trends and update policies as needed.
Leadership will support a culture of transparency and accountability, encouraging staff to report all incidents without fear of reprisal.

The Plan of Correction will be revisited annually or upon identification of further violations.

16c Written Incident Report (continued)

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/16/2025)

57b - 1 Hour/Day

2. Requirements

2600.
57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On [redacted], there were 49 residents in the home, requiring a minimum of 49 hours of direct care service. On this day, only 47 hours of direct care staffing was provided.

On [redacted] there were 49 residents in the home, requiring a minimum of 49 hours of direct care service. On this day, only 42 hours of direct care staffing was provided.

Plan of Correction ***Accept ([redacted] - 08/29/2025)***

Upon notification of the deficiency, the supervisor and administrator promptly reviewed the existing schedule to ensure adequate staffing coverage.
Effective 8/1/2025, direct care schedule will undergo weekly review by the supervisor and administrator. Each assessment will entail reconciliation of resident census, acuity levels, and required staffing hours to ensure full compliance.
Prior to finalizing the staff schedule, the current resident count and individual care requirements will be analyzed by the administrator to determine the exact allocation of direct care hours needed for each shift.
Once approved, daily oversight by the supervisor or administrator will provide timely updates, accommodating staff absences to maintain adequate coverage.
All direct care hours will continue to be recorded daily, with documentation preserved for internal audit and regulatory inspection. Deviations from the mandated hours will be promptly flagged and addressed by administrator.
Ongoing feedback will be requested from staff and residents to highlight improvement opportunities and assure that staffing consistently meets or exceeds regulatory standards.
Direct care schedules and time logs will be reviewed daily by supervisor or administrator.
Discrepancies discovered during audits will be reported to administrator and result in immediate corrective measures.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/16/2025)

57d - Waking Hours

3. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

57d Waking Hours *(continued)*

Description of Violation

On [redacted], a total of 49 hours of direct care was required. However, only 35 of the required hours, or 71.4 percent, were provided during waking hours.

Plan of Correction ***Accept ([redacted] - 08/29/2025)***

Upon notification of the deficiency, the supervisor and administrator promptly reviewed the existing schedule to ensure adequate staffing coverage.
Effective 8/1/2025, direct care schedule will undergo weekly review by the supervisor and administrator. Each assessment will entail reconciliation of resident census, acuity levels, and required staffing hours to ensure full compliance.
Prior to finalizing the staff schedule, the current resident count and individual care requirements will be analyzed by the administrator to determine the exact allocation of direct care hours needed for each shift.
Once approved, daily oversight by the supervisor or administrator will provide timely updates, accommodating staff absences to maintain adequate coverage.
All direct care hours will continue to be recorded daily, with documentation preserved for internal audit and regulatory inspection. Deviations from the mandated hours will be promptly flagged and addressed by administrator.
Ongoing feedback will be requested from staff and residents to highlight improvement opportunities and assure that staffing consistently meets or exceeds regulatory standards.
Direct care schedules and time logs will be reviewed daily by supervisor or administrator.
Discrepancies discovered during audits will be reported to administrator and result in immediate corrective measures.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/16/2025)

85e - Trash Outside Home

4. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [redacted] at 9:00 AM, a large dumpster on the side of the residence, and two smaller trash cans in the backyard of the residence were all uncovered. In the tree line of the side of the residence there was an old toolbox and pieces of broken concrete. In the lawn by the patio there was an abundance of spent cigarette butts.

Plan of Correction ***Accept [redacted] - 08/29/2025)***

7/31/2025, All uncovered trash cans and dumpsters were immediately secured with proper lids to ensure compliance with regulation 2600
on 8/4/2025, The old toolbox and broken concrete pieces were promptly removed from the tree line and disposed of appropriately.
All spent cigarette butts in the lawn by the patio were collected and properly discarded to restore cleanliness to the outdoor environment. Staff members will continue to monitor the patio, which serves as the designated smoking area for residents, during the 7 3 and 3 11 shifts, and will clean up cigarette butts as required.

85e - Trash Outside Home (continued)

Staff will continue to encourage residents to properly use the designated smoking extinguisher containers for extinguishing all cigarettes.
8/1/2025, Staff have been re-educated on the importance of maintaining covered trash receptacles and on procedures for ongoing monitoring. (see attached training record)
on 8/1/2025, Staff assigned to the designated smoking patio will continue to monitor and clean up cigarette waste during both the 7-3 and 3-11 shifts. This ensures ongoing attention to the maintenance of outdoor spaces and supports sustained regulatory compliance.

8/1/2025, Daily, regular inspections by desigated staff member of outdoor areas—including the tree line and patio —are now scheduled to ensure removal of any debris or litter, including cigarette butts and large discarded items.

8/1/2025, A log has been created and implemented to document and verify that all outdoor trash receptacles (cans and dumpsters) are checked and kept covered every shift.
(See attached log)

Completed logs will be retained in the home for 2 monthly, then discarded

Beginning 8/7/2025 the owner and maintenance person will perform weekly walkthroughs to verify compliance with 2600. and to address any emerging issues promptly.
Any recurrence of uncovered receptacles or outdoor debris will be documented, and corrective action will be taken immediately.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/11/2025)

88a - Surfaces

5. 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

Throughout the first floor there were large chunks of vinyl flooring broken away including in front of the medication room between the living and dining area.

The ceilings in the emergency stairwell, the first-floor bathroom, and the dining area all showed signs of water damage. The ceilings were dipping and the paint is peeling away.

Plan of Correction ***Accept [redacted] - 08/29/2025)***

On 8/1/2025, the owner and maintenance placed heavy-duty tape securely over all broken vinyl flooring sections to reduce trip hazards and increase visibility of hazard areas.

88a - Surfaces (continued)

On 8/1/2025, Owner notified maintenance team promptly and requested urgent scheduling of repairs.
8/1/2025, the administrator communicated with direct care staff to monitor the taped areas and report any changes or increased risk immediately.

8/4/2025, Owner and maintenance conducted a thorough inspection of all resident rooms, bathrooms, and hallways within the facility.
maintenance documented the condition of flooring in each area, identifying any additional hazards or damaged surfaces.
they created a log of all required repairs and prioritized according to resident safety risk.

8/6/2025, All repairs for identified damaged areas have been scheduled with the facility's maintenance department and external flooring contractor scheduled to begin 8/27/2025.
Repairs are to be completed within 45 days from the date of this report, as documented in the facility maintenance schedule.
Until repairs are completed, regular checks (at least every shift) will be performed to ensure that the tape remains secure and no new hazards have developed.
Upon completion of repairs, all areas will be re-inspected by the facility Owner and maintenance person to ensure surfaces are safe and compliant

8/1/2025, all staff were instructed to continue to promptly report flooring issues to management and recorded findings in the log.

Beginning, 8/6/2025 environment rounds will be conducted weekly by the facility Owner and maintenance and supervisor to monitor all surfaces and ensure timely identification and remediation of similar hazards.
Maintenance logs will be reviewed during monthly quality assurance meetings to track completion and effectiveness of corrective actions.
Feedback from residents and staff regarding safety concerns will be actively solicited and addressed promptly.

All repairs are scheduled to begin 8/27/2025 and completed within 45 days (10/13/2025) The Maintenance Supervisor and owner are responsible for coordinating and ensuring timely completion of repairs.
The Facility Owner and Administrator will oversee implementation of this plan and verify compliance with Regulation 2600

See photos for completed repairs

All areas, except the dining area, have been repaired. The dining area ceiling was inspected and found structurally stable. However, leaves caused a drain backup, leading to roof backflow."
Repairs as follows:
• Emergency stairway ceiling: Repaired (see Attached photo)
• First floor community bathroom ceiling: (Repaired See photo)
• Dining area ceiling: Pending repair (scheduled for completion by 08/29/2025)
The dining area does not pose an immediate threat to residents:

88a Surfaces (continued)

• Continue to restrict access to the dining area ceiling directly beneath the damaged section until repairs are completed.
• Post clear signage and barriers to ensure the safety of residents and staff.
• Monitor the dining area ceiling daily for any further deterioration or safety hazards.
Scheduled Repair
• Dining area ceiling will be fully repaired no later than 8/29/2025.
• Repair process includes:
• Removal of any loose or damaged material
• Inspection of underlying structure for further water damage or mold
• Application of water resistant materials
• Repainting using moisture resistant paint
Documentation of the repair, including before and after photos, will be maintained in facility records.
• Upon completion of the dining area ceiling repair, The owner and will conduct a final inspection to ensure quality and safety standards are met.

8/1/2025 all staff were trained to report and log any new signs of water damage immediately. (see training log)

Beginning 9/1/2025, Owner will inspect all ceilings in common areas quarterly for signs of water intrusion, staining, or structural issues.
upon completion of this project the owner and maintenance with perform monthly home inspection

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/11/2025)

95 - Furniture and Equipment

6. Requirements

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

Description of Violation

At least 3 benches in the back yard area were broken. 2 benches that were constructed of wood and cement had missing planks in the seat of the bench exposing large screws. A plastic bench near the fence was not secured at the bottom creating a potential hazard if someone was to sit on it.

Plan of Correction ***Accept [redacted] - 08/29/2025)***

• Broken benches were quickly closed off to prevent use and injury.
• On 8/4/2025, missing planks on the wooden and cement benches were replaced with new materials, and all fastenings were checked for safety.
• The plastic bench was re secured at the base to ensure stability and safe usage.
• After repairs, each bench was tested to confirm they were safe and functional before being returned to service.

95 Furniture and Equipment (continued)

• A full inspection of all chairs, benches, and seating areas throughout the property was completed to identify any additional hazards or repairs needed.
• No further unsafe seating was found at the time of inspection.
• Beginning 9/2/2025, The owner and the maintenance person will monitor all seating and yard fixtures on a weekly basis to ensure continued safety and usability.
• Direct care staff will monitor for needed repairs, report them immediately, and record them in the maintenance log.
• A scheduled monthly inspection routine will be implemented. The maintenance team will document the condition of all benches and seating and address any issues immediately.
• All repairs and inspections will be documented in a maintenance record for record keeping and reference. Maintenance logs will be stored at the residence for review and quality assurance purposes for 3 months.
• Staff members have been instructed to promptly report any indications of damage or instability in benches, chairs, or other yard features to the owner or maintenance personnel, and to document such incidents in the log. (see staff training sheet)
• Staff will be apprised of the updated inspection and repair schedule to promote continued vigilance and timely reporting of any issues.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/11/2025)

131f - Fire Extinguisher Inspection

7. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the back patio area has not been inspected by a fire safety expert since 2019.

Plan of Correction ***Accept ([redacted] - 08/29/2025)***

• The non compliant fire extinguisher was promptly removed from the back patio.
• A new, fully inspected fire extinguisher was installed in its place.
• Designated personnel promptly performed a comprehensive inspection of all fire extinguishers on the premises to verify that each unit was current with required inspections and fully compliant with applicable regulations.
• Beginning 9/15/2025, a designated staff member will perform monthly inspections of all fire extinguishers across the premises.
• For each inspection, the staff member will record the following details for every extinguisher:
• Exact location
• Expiration date
• Signature of the inspecting staff member
If an extinguisher is determined to be non compliant, the administrator will be informed promptly for corrective action.
• Inspection logs will be maintained and kept on site at the home for a period of two months.
• After two months, logs will be properly discarded in accordance with documentation policies.
• Assigned and designated staff members will be trained on fire extinguisher inspection protocol, documentation, and notification procedures.
• Accountability will be ensured through regular review of inspection logs by supervisory staff.

131f - Fire Extinguisher Inspection (continued)

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] 09/11/2025)

183e - Storing Medications

8. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [redacted] a [redacted] for resident [redacted] with an open date of [redacted] was in the home's medication cart. According to the manufacturer's instructions the unused portion of this medication should be discarded 28 days after opening.

Plan of Correction ***Accept [redacted] - 08/29/2025)***

• The expired Lantus insulin pen was immediately removed from service and replaced with a new pen. The new pen was clearly labeled with the new open and discard dates.
• The medication technician conducted a thorough check of all other insulin pens and vials in the medication cart and removed any items at risk of expiration.
• The resident's family and primary care provider (PCP) were notified promptly about the incident and the corrective actions taken.
• Beginning 8/1/2025, a log has been created for all medication technicians on duty. Each med tech must inspect and document the condition and expiration date of all insulin pens prior to administration, ensuring proper use and timely disposal.
• Documentation on the log must include:
• Date and time of inspection
• Name of med tech completing the inspection
• Expiration date to ensure confirmation that the pen is within the safe use period
• Any discrepancies or actions taken, if needed
• The shift supervisor will check all insulin pens and review the logs weekly to ensure completion and proper compliance.
• Any discrepancies or non-compliance will be immediately reported to the administrator for further review and corrective action.
• The administrator will conduct a monthly audit of each medication storage area and review the logs for accuracy and thoroughness.
• All inspection logs will be kept in the home for a minimum of two full completed months for audit and quality assurance review.
• On 8/1/2025, All med techs and supervisors will receive in-service education on proper insulin pen storage, labeling, and timely disposal, as per manufacturer guidelines.
• Training will include instruction on completing the new pen inspection log and the importance of compliance to prevent medication errors.
• Inservice will be conducted monthly, to ensure continuous compliance
• Random spot-checks will be conducted by the administrator or designee to ensure logs are current and procedures are followed.

183e - Storing Medications (continued)

• Any identified issues will be addressed promptly with corrective action and, if needed, additional staff education.
• Review of this corrective plan and its effectiveness will be discussed in monthly staff meetings for ongoing improvement.

see attached log

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/11/2025)

225a - Assessment 15 Days

9. 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

An assessment was not completed for resident[redacted] who was admitted to the home on [redacted].

Plan of Correction ***Accept [redacted] - 08/29/2025)***

Upon discovery on 7/31/2025, the administrator immediately completed the initial support plan for resident [redacted]
An audit of all resident records was conducted by the administrator on 8/4/2025. No other incomplete support plans were found.R

on 7/31/2025, A tickler file was created for resident [redacted] The tickler file is an ongoing tracking system for all required documentation related to support plans.
The administrator is responsible for maintaining the tickler file and ensuring all deadlines are met for new and current residents.
on 9/1/2025, The tickler file will be reviewed monthly by supervisor to identify upcoming due dates and required documentation for timely completion and report upcoming RASP to Administrator.

on 9/10/2025, The administrator will verify, at least monthly, that all new admissions have an initial support plan developed within 30 days, using the tickler file as an audit tool.
Results of these monthly audits will be documented and reported at facility quality assurance meetings.
If any instance of late or missing documentation is found, corrective action will be taken immediately, and the systemic review process will be re-evaluated for further prevention.

The supervisor will check for completion at least 5 days after due date and report findings to administrator.

see attached RASP for resident [redacted]

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/16/2025)

227a - Support Plan 30 Days

10. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident [redacted] was admitted on [redacted] however, the resident's initial support plan was not completed.

Plan of Correction ***Accept ([redacted] - 08/29/2025)***

Upon discovery on 7/31/2025, the administrator immediately completed the initial support plan for resident [redacted]
An audit of all resident records was conducted by the administrator on 8/4/2025. No other incomplete support plans were found.

on 7/31/2025, A tickler file was created for resident [redacted] The tickler file is an ongoing tracking system for all required documentation related to support plans.
The administrator is responsible for maintaining the tickler file and ensuring all deadlines are met for new and current residents.
on 9/1/2025, The tickler file will be reviewed monthly by supervisor to identify upcoming due dates and required documentation for timely completion and report upcoming RASP to Administrator.

on 9/10/2025, The administrator will verify, at least monthly, that all new admissions have an initial support plan developed within 30 days, using the tickler file as an audit tool.
Results of these monthly audits will be documented and reported at facility quality assurance meetings.
If any instance of late or missing documentation is found, corrective action will be taken immediately, and the systemic review process will be re-evaluated for further prevention.

The supervisor will check for completion at least 5 days after due date and report findings to administrator.

See attached RASP for Resident [redacted]

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented ([redacted] - 09/16/2025)

252 - Record Content

11. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.

252 - Record Content *(continued)*

7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident [redacted] record does not include a photograph of the resident that is no more than 2 years old.
Resident [redacted]'s record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Accept [redacted] - 08/29/2025)***

on 7/31/2025, updated photographs for residents [redacted] and [redacted], were taken ensuring that each photo contained, name and date photo and added to their records.

On 8/4/2025, a designated direct care staff member has been appointed to oversee the maintenance and updating of resident photographs. This individual has been trained about regulatory requirements, use of the tickler file, and communication protocols with residents and families.
on 8/10, Direct care staff person, conducted an audit of all records and updated all photos and completed the update by 8/13/2025.
This individual will be responsible implementing a complete tickler file for photos by 9/10/2025
and must maintain an up-to-date inventory of all resident records, with a specific focus on photographic documentation.
[redacted] will create a tickler file to streamline the process and prevent future violations.
The tickler file will be maintained in hard copy format to ensure accessibility and redundancy.
The tickler file will include each resident's name, admission date, last photo date, and next photo due date. and stored in a box by month taken.

252 - Record Content (continued)

Documentation of actions taken will be recorded in the tickler file and in the resident's official record.
Upon admission, a photograph will be taken of each new resident and immediately added to their record, with the date and name clearly marked.
each resident's record will be reviewed upon admission and at least annually thereafter.
The designated staff member will conduct quarterly audits of all resident records to verify compliance with the two-year photograph requirement.
For current residents, the tickler file will identify any upcoming photograph expiration dates, triggering timely updates.
If a resident refuses or is unavailable for a photo update, documentation of the reason and efforts made will be included in the record.
For residents discharged, deceased, or transferred, the tickler file will be updated accordingly and the record archived.
Periodic refresher sessions will be offered to reinforce best practices and address any questions or concerns. Staff will be notified of any changes in policy or procedure related to photographic documentation.
The tickler file system will be reviewed by administrator, annually to assess its effectiveness and identify opportunities for improvement.
All updates, audits, and communications will be logged for reference during inspections and internal reviews.

Quarterly chart audits will begin within the first month after implementation beginning 10/10/2025 and completed by appointment direct care member..
The administrator will meet with the designated person bi-monthly to review and refine the system and as needed based on regulatory changes or identified issues.
The Home Administrator will serve as the backup to the designated direct care member.

see updated photos

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 09/16/2025)