pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **PRESBYTERIAN SENIOR CARE INC**
LEGAL ENTITY

To operate **SOUTHMINSTER PLACE**
NAME OF FACILITY OR AGENCY

Located at **880 SOUTH MAIN STREET, WASHINGTON, PA 15301**
(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 **90** (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 **December 12, 2025** until **June 12, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **415931**

ISSUING OFFICER

Juliet Marsala
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: DECEMBER 12, 2025

[redacted]
Presbyterian Senior Care Inc.
880 South Main Street
Washington, Pennsylvania 15301

RE: Southminster Place
License/COC #: 415931

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on August 4, 2025, August 5, 2025, August 8, 2025, and October 27, 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 (license number 415930) dated June 24, 2025 – June 24, 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); (5) and 55 Pa. Code § 20.71(a)(2); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from DECEMBER 12, 2025 to JUNE 12, 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 11 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: *SOUTHMINSTER PLACE* **License #:** *41593* **License Expiration:** *06/24/2026*

Address: *880 SOUTH MAIN STREET, WASHINGTON, PA 15301*

County: *WASHINGTON* **Region:** *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *PRESBYTERIAN SENIOR CARE INC*

Address: *880 SOUTH MAIN STREET, WASHINGTON, PA, 15301*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date:** *04/11/2002* **Issued By:** *Township of South Strabane*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *70* **Waking Staff:** *53*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date:** *08/08/2025*

Inspection Dates and Department Representative

08/04/2025 - On-Site: [redacted]
08/05/2025 - On-Site:
08/08/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served:** *63*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *63*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *7* **Have Physical Disability:** *0*

Inspections / Reviews

08/04/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/18/2025*

09/26/2025 - POC Submission

Submitted [redacted] **Date Submitted**: *10/08/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/01/2025*

10/02/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/08/2025*

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

12/01/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *10/08/2025*

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

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 8/4/25 at approximately 11:30 a.m., the door to the 3rd floor nurse's station was unlocked and the office unattended. There were no staff in the area outside of the nurse's station. Resident #1 and resident #2's charts were setting on the countertop and contained protected health information to include:

** Resident #1's Order Summary Report dated [redacted]27/25.*

** Face sheet for resident #1 that included the resident's date of birth, marital status, race, religion, Medicare ID number; secondary insurance policy #, emergency contact information and diagnoses.*

** Resident #1's POLST.*

** Resident #1's Personal Care Admission Agreement dated [redacted]3/25.*

** Face sheet for resident #2 that included the resident's date of birth, marital status, race, religion, Medicare ID number; secondary insurance policy #, emergency contact information and diagnoses.*

** Resident #2's medical evaluation (DME) completed [redacted]25.*

Plan of Correction ***Accept[redacted] - 10/02/2025)***

In response to the violation on 8/4/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken on 8/4/2025 by the Maintenance Technician to check the lock on the nursing station door and ensure the keys were working correctly to lock the door. In the process of investigating, it was identified that the nurse assigned to the floor that day had stated that the key to the door wasn't working to lock the door, but the maintenance technician identified that the nurse was using the wrong key on the ring. The door to the nursing station was then locked at that time. On 8/4/2025, the Director of Nursing began to implement education to the nurse that had left the door open on the components of 2600.17 and the importance of keeping records confidential.

To enhance currently compliant operations:
Effective 8/11/2025, the Administrator and Resident Services Director began education to the nursing team members on the components of 2600.17 and their role in compliance, with an in-service completion date of 8/17/2025.

Beginning 8/18/2025, the Administrator and/or Director of Resident Services performed random audits of the nursing stations daily x 5 and will follow weekly x 4 and monthly x 3 to maintain ongoing compliance with the components of 2600.17. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

Licensee's Proposed Overall Completion Date: *10/01/2025* Not Implemented [redacted] 12/1/25)

23a - Activities of Daily Living Assistance

2. Requirements

2600.

23a - Activities of Daily Living Assistance *(continued)*

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

As the result of a speech pathology consult and barium swallow on 6/17/25, resident #4 was recommended a "thin liquids, mechanical soft diet; maintain upright posture during/after eating for 30 mins, slow single presentation, small sips/bites, reduce distractions, encourage timely oral prep and swallow, alternate between small bites and sips of food/liquid, check mouth frequently for oral residue/pocketing. Monitor for signs of aspiration: gurgly voice, throat clearing, upper respiratory infection, cough, pneumonia, right lower lobe infiltrates." However, during observation of lunchtime meals on 8/5/25 and 8/8/25, there were no direct care staff in the home's first-floor dining room where resident #4 eats meals.

Plan of Correction ***Accept [redacted] - 10/02/2025)***

In response to the violation on 8/8/2025 by the Bureau of Human Services Licensing, the facility immediately implemented a stop gap plan by assigning a CPR/First Aid trained team member to the dining room to monitor resident # 4 and cover the need in the meantime while the home further evaluated plans to meet the needs of residents with modified texture diets. This began 8/9/2025 upon the next occurrence of a meal. Understanding that not all residents with a modified texture diet require monitoring during meals, the home has requested an evaluation from the doctor and/or a speech therapy consult to evaluate the resident's current needs in this area. Nursing staff began to place calls to physicians of residents affected beginning 9/8/25 after receiving the deficiencies from the department.

The home's administrative leadership met on 9/10/2025 to discuss current processes within the home regarding management of altered texture dietary needs. The administrator solicited the help of a registered dietitian, speech therapist, and Director of Dining Services from the skilled nursing community on the campus to review internal processes for best next steps in a meeting held 9/10/2025. On 9/9/2025, the Resident Services Director completed a whole-house audit of residents with an altered texture diet as well as audit of support plans to identify all residents whose support plans indicated a need for monitoring during meals. The audit revealed that of the 8 residents in-house with altered texture diets, only resident # 4's support plan indicated a need for monitoring during meals. For residents ordered an altered texture diet, a physician consult and/or speech therapy consult will be implemented to assess current level of independence with dining. Resident #4's meals in the dining room will be monitored by a CPR/First Aid trained team member unless the attending physician or speech therapist deems the resident capable of independently eating in the dining room. Moving forward, any other residents whose support plans indicate a need for monitoring will be monitored by a CPR/First Aid trained team member assigned to the dining room.

Beginning 9/16/2025, interdisciplinary team members were in-serviced on the components of both 2600.23.a as well as their role in maintaining ongoing compliance with the standards of the regulation. In addition, the in-service solidified a new process implementation of assigning a CPR/First Aid trained team member to the dining room for meals with the expectation that the team member stays in the dining room for the duration of the meal process. In-service completion date was 9/17/2025.

Beginning 9/22/2025, the Resident Services Director/designee will complete audits of the dining room to ensure that a CPR/First Aid trained team member is present in the dining room for meals x5 days daily, weekly x 4, and monthly x 3. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

23a - Activities of Daily Living Assistance *(continued)*

Licensee's Proposed Overall Completion Date: *10/01/2025* **Not Implemented [redacted] 12/1/25)**

42b - Abuse

3. Requirements

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

Description of Violation

Resident #3 was admitted to the home on [redacted]/24. According to resident #3's admission diagnoses on [redacted] "Move in Record" [face/transfer sheet], the medical evaluation (DME) completed [redacted] 17/24, and initial assessment and support plan (RASP) completed [redacted] 22/24, the resident had a diagnosis of dysphagia. According to the Southminster Place Medication Review Report dated [redacted]/18/24, the ordered diet for this resident was Controlled Carb diet, Mechanical soft texture, regular/thin consistency. Resident #3's assessment and support plan completed [redacted]/22/24, indicates in the "Eating" section that, although coded as A=Independent, "Resident does have a history of pocketing food at previous facility." The plan to meet this service need is "Monitor eating for pocketing of food. Resident is on a mechanical soft diet." In Section 2: Medical, Dental, Dietary, and Sensory Needs section of the resident assessment and support plan, the Medical Diagnoses section includes the diagnosis of "Dysphagia, oropharyngeal phase." The Plan to Meet Medical Need indicates "monitor my swallowing with meals. Monitor for pocketing of food as well. Resident ordered mechanical soft diet." This service need was to be completed daily by DCS [direct care staff]. The Dietary Need section of the assessment indicates "I had difficulty swallowing and pocketing of food at [redacted]r" and the Plan to Meet Dietary Need is "Please monitor me for swallowing difficulties and make sure I a get a mechanical soft diet as ordered." This plan is to be completed daily by DCS [direct care staff]. The Dental Need section indicates that resident has "Upper denture. Had lower partial but it was lost at previous facility."

However, on [redacted]/25, at approximately 12:05 p.m. interviews indicated the resident was served beef stroganoff with meat measuring approximately a quarter and was chewy. Interviews indicated the resident started choking and this caused [redacted] table mate to call out that the resident needed help. There were no direct care staff in the dining room at that time. Dining staff person A went to get the nurse, staff person B, from the first floor nurse's station just across the hall. 9-1-1 was called. Staff person B attempted to do the Heimlich Maneuver several times on resident #3, and when resident #3 went unresponsive, no action beyond the Heimlich Maneuver was taken by staff due to a DNR POLST being in place for the resident. Resident #3 was pronounced [redacted] on the residents date of death at 12:26 p.m. by EMS.

The causes of death listed on the resident's death certificate include:

a. Alzehimer's Dementia
b. Dysphagia

Plan of Correction ***Accept [redacted] - 10/02/2025)***

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or of the findings/conclusions set forth in the statement of deficiencies. The plan of correction has been prepared and/or executed solely because it is required by the provisions of state regulations.

In response to the violation of 2600.42.b, upon notification of the deficiency by the Pennsylvania Bureau of Human Services Licensing, on 9/10/2025 the facility leadership met to discuss current processes within the home regarding management of altered texture dietary needs. The administrator solicited the help of a registered dietitian, speech

42b - Abuse (continued)

therapist, and Director of Dining Services from the skilled nursing community on the campus to review internal processes for best next steps in that meeting held 9/10/2025.

On 9/9/2025 , the Resident Services Director completed a whole-house audit of residents with an altered texture diet as well as audit of support plans to identify all residents whose support plans indicated a need for monitoring during meals. The audit revealed that of the 8 residents in-house with altered texture diets, only resident # 4's support plan indicated a need for monitoring during meals. For residents ordered an altered texture diet, a physician consult and/or speech therapy consult will be implemented to assess current level of independence with dining. Resident #4's meals in the dining room will be monitored by a CPR/First Aid trained team member. Moving forward, any other residents whose support plans indicate a need for monitoring will be monitored by a CPR/First Aid trained team member assigned to the dining room.

On 9/16/2025 and 9/17/2025, dining services team members were educated on texture-modified diets according to International Dysphagia Diet Standardization Initiative by a registered dietitian, Dining Services Manager, and the Campus Director of Dining Services, which included discussion on proper preparation as well as identification of the different standards. The team was also in-serviced on the components of 2600.23.a and 2600.42.b. with a completion date of 9/17/2025.

Beginning 9/16/2025, interdisciplinary team members were in-serviced on the components of both 2600.23.a and 2600.42.b as well as their role in maintaining ongoing compliance with the standards of these regulations. In addition, the in-service included a new process implementation of assigning a CPR/First Aid trained team member to the dining room for meals with the expectation that the team member stays in the dining room for the duration of the meal process. In-service completion date was 9/18/2025.

Beginning 9/22/2025, the Resident Services Director/designee will complete audits of the dining room to ensure that a CPR/First Aid trained team member is present in the dining room for meals x5 days daily, weekly x 4, and monthly x 3. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

Licensee's Proposed Overall Completion Date: *10/01/2025* Not Implemented [redacted] - 12/1/25)

81b - Resident Personal Equipment

4. 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

On 8/4/25, the bedside mobility devices on the beds of resident #5 and resident #6 were not secured to the bed frames. The bed canes were only slid under the mattresses and not secured to the bed frames causing a risk of entrapment if the bed canes shifted.

Plan of Correction ***Accept*** [redacted] ***- 10/02/2025)***

In response to the violation on 8/4/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken on 8/4/2025 by the Maintenance Technician, Campus Building Services Director, and Administrator to

81b - Resident Personal Equipment (continued)

assess the bedside mobility devices for residents #5 and #6. On 8/4/2025, Resident #6's bedside mobility device was secured to the bedframe to prevent any shifting and possibility of entrapment because of shifting. On 8/4/2025, resident #5's bed frame did not allow safely securing the bedside mobility device, so the Administrator contacted the resident's family to inquire if they would be agreeable to Southminster Place providing a hospital bed similar to resident #6's bed, at no cost to the resident or family. Resident #5 and family were agreeable to this plan and the resident's bed was switched out for a hospital bed with a frame suitable for securing the bedside mobility device. On 8/4/2025, the device was then secured to the bedframe by the Maintenance Technician and the Campus Building Services Director.

A whole house audit was completed 8/5/2025 by the Administrator ensuring that no other bedside mobility devices had been installed incorrectly at Southminster Place and not secured properly to the bedframes.

To enhance the currently compliant operations:
Effective 8/11/2025, the Administrator began education to the nursing team members on the components of 2600.81.b and the requirement to alert the Administrator and/or Director of Resident Services if a bedside mobility device appears to not be secured to the bedframe or has come loose in any way, with an in-service completion date of 8/17/2025.

Effective 8/18/2025, the Administrator and/or Director of Resident Services began to perform audits of all bedside mobility devices weekly x 4 and monthly x 3 to maintain ongoing compliance with the components of 2600.81b. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

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

Implemented [redacted] - 12/01/2025)

103e - Left Overs

5. 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

On 8/4/25 at 2:30 p.m., there was an undated pan of almond cake with approximately 1/3 of the cake remaining in the home's walk-in cooler.

Plan of Correction ***Accept [redacted] - 10/02/2025)***

In response to the violation on 8/4/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken by the Dining Services Manager to remove the pan of almond cake from the cooler and discard it on 8/4/2025. To clarify, there was no intention of serving the almond cake to any residents a second time. The almond cake had been placed back in the cooler to be given to team members who might have wanted the leftovers but was not properly labeled and dated as such.

To enhance the currently compliant operations, on 8/4/2025 the Dining Services Director in-serviced dining services team members on 8/4/2025 on the components of 2600.103.f, specifically noting that all food stored anywhere

103e - Left Overs (continued)

within the kitchen is to be labeled and dated at all times.
Effective 8/5/2025, the Dining Services Manager implemented an audit tool for all food storage areas within the kitchen to be inspected twice daily (AM and PM) ensuring the components of 2600.103.e are in full compliance. This process will continue indefinitely.

Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

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

Implemented [redacted] - 12/01/2025)

103g - Storing Food

6. Requirements

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

Description of Violation

On 8/4/25 at 2:30 p.m., there were 12 biscuits left over from today's breakfast in an uncovered clear plastic bin.

Plan of Correction ***Accept[redacted] - 10/02/2025)***

In response to the violation on 8/4/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken by the Dining Services Manager on 8/4/2025 to remove the pan of individually wrapped biscuits from the uncovered clear plastic bin from the cooler and discard it.

To enhance the currently compliant operations, on 8/4/2025 the Dining Services Director in-serviced dining services team members on the components of 2600.103.g, specifically noting that all food stored anywhere within the kitchen is to be labeled, properly sealed, and dated at all times.

Effective 8/5/2025, the Dining Services Manager implemented an audit tool for all food storage areas within the kitchen to be inspected twice daily (AM and PM) ensuring the components of 2600.103.g are in full compliance. This process will continue indefinitely.

Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

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

Implemented [redacted]/01/2025)

103i - Outdated Food

7. Requirements

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

Description of Violation

On 8/4/25 at 2:30 p.m., the following undated items were in the home's walk-in freezer in the home's kitchen:

103i - Outdated Food (continued)

** An undated, unlabeled plastic bag containing five pastry shells*
** An undated Ziploc bag containing two pizza shells*

Plan of Correction ***Accept [redacted] - 10/02/2025)***

In response to the violation on 8/4/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken on 8/4/2025 by the Dining Services Manager to remove the unlabeled plastic bag containing five pastry shells and the unlabeled Ziplock bag containing two pizza shells from the cooler and discard them.

To enhance the currently compliant operations, on 8/4/2025 the Dining Services Director in-serviced dining services team members on the components of 2600.103.i, specifically noting that all food stored anywhere within the kitchen is to be labeled, properly sealed, and dated at all times.

Effective 8/5/2025, the Dining Services Manager implemented an audit tool for all food storage areas within the kitchen to be inspected twice daily (AM and PM) ensuring the components of 2600.103.i are in full compliance. This process will continue indefinitely.

Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

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

Implemented [redacted] - 12/01/2025)

141b1 - Annual Medical Evaluation

8. Requirements

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

Description of Violation

Resident #7's annual medical evaluation completed [redacted]/25, did not include the license number for the medical professional who completed the evaluation.

Plan of Correction ***Accept [redacted] - 10/02/2025)***

In response to the violation on 8/8/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken on 8/8/2025 by the Resident Services Director to reach out to resident #7's physician and identify the physician's medical professional license number and have the provider update the form to bring it into regulatory compliance. The form was updated 8/11/2025 after hearing back from the physician.

On 8/11/2025, the Resident Services Director began a whole-house audit of DME's to assess for compliance with Chapter 2600 regulations on this document with a completion date of 8/22/2025.

To enhance currently compliant operations, effective the week of 9/29/2025, the Resident Services

141b1 - Annual Medical Evaluation (continued)

Director/designee will complete monthly audits of all resident's annual medical evaluations due in that month as well as all new resident move-ins in that corresponding month times 4 months. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025. In addition, the process of completing a monthly audit of DMEs will be an expectation to include in QM meetings moving forward ongoing.

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

Implemented [redacted] - 12/01/2025)

183b - Meds and Syringes Locked

9. Requirements

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

Description of Violation

On 8/4/25 at approximately 11:30 a.m., the door to the 3rd floor nurse's station was unlocked and the office unattended. There were no staff in the area outside of the nurse's station. Numerous resident medications were stored in unlocked cupboards in the nurse's station. The wall cabinet on the left had miscellaneous medications to include:
** Three bottles of donepezil with pharmacy labels for Resident #8 – Donepezil Hcl 5mg tablet – take 1 tablet orally once pre day for 90 days.*
** A bottle of amlodipine besylate 5mg tab - with pharmacy label for resident #8 – take 1 tablet orally once per day for 90 days.*
** Three boxes (2 closed and 1 opened) of albuterol sulfate inhalation solution, 0.083% 2.5mg/3ml each carton contains 30X3ml sterile unit-dose vials.*
** A clear zip top bag containing an albuterol inhaler for resident #9 with label – inhale 1 puff by mouth every 4 hours as needed for shortness of breath.*
** A bottle of Dulcolax with resident #10 written on it and handwritten directions – 30ml PRN constipation.*
** Several boxes of AdvilLiqui-Gels 200mg – 80 capsules.*
** Numerous boxes of eye drops.*

Plan of Correction ***Accept [redacted] - 10/02/2025)***

In response to the violation on 8/4/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken on 8/4/2025 by the Maintenance Technician to check the lock on the nursing station door and ensure the keys were working correctly to lock the door. In the process of investigating, it was identified that the nurse assigned to the floor that day had stated that the key to the door wasn't working to lock the door, but the maintenance technician identified that the nurse was using the wrong key on the ring. The door to the nursing station was then locked at that time. The Director of Nursing began to implement education to the nursing staff on the components of 2600.183.b and the importance of keeping medications locked within the med room and/or medication carts only.

To enhance currently compliant operations:
Effective 8/11/2025, the Administrator and Resident Services Director began education to the nursing team members on the components of 2600.183.b and their role in compliance, with an in-service completion date of 8/17/2025.

183b - Meds and Syringes Locked (continued)

Effective 8/18/2025, the Administrator and/or Director of Resident Services performed random audits of the nursing stations daily x 5 and will follow weekly x 4 and monthly x 3 to maintain ongoing compliance with the components of 2600.183.b. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

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

Implemented [redacted] - 12/01/2025)

184a - Resident's Meds Labeled

10. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

As of 3/2/25, resident #7 is ordered Basaglar Kwikpen - inject as per sliding scale: if 1-70 = 10 units; 71-999 = 20 units subcutaneously one time a day for DM. However, on 8/5/25, the pharmacy label for this medication indicated Basaglar 100 unit/ML Kwikpen – inject 18 units SubQ daily.

Resident #11 is ordered Latanoprost 0.005% ophthalmic solution – instill 1 drop in both eyes at bedtime. However, on 8/5/25 at 3:01 p.m., there was a bottle of this medication in a zip-top bag with handwritten directions including "Resident name, room #, latanoprost 0005% - instill 1 drop in both eyes QHS Dx: glaucoma Dr Paul" in the medication cart. There was no pharmacy label on this medication. The only label was on a box of the medication kept in the refrigerator.

Resident #12 is ordered Eliquis 2.5mg twice daily. However, on 8/5/25 at approximately 2:15 p.m., there was a bottle of Eliquis 5mg tablets with pharmacy label indicating "take 1 tablet by mouth twice a day; "1/2 tab" was hand-written in marker on the label.

Resident #12 is ordered Pravastatin 10mg – Give 1 tablet by mouth at bedtime every other day. However, on 8/5/25

184a - Resident's Meds Labeled (continued)

at approximately 2:30 p.m., the bottle of this medication with pharmacy label for resident #12 indicated Pravastatin Sodium oral tablet 10mg – Give 1 tablet by mouth nightly.

Plan of Correction ***Accept [redacted] - 10/02/2025)***

In response to the violation on 8/8/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken on 8/8/2025 by the Resident Services Director to clarify the order for Resident # 5's Lorazepam order with hospice and a new changed dosage sticker was placed on 8/8/2025. For resident #7, the order was clarified with the physician for the Basaglar Kwikpen and a changed dosage sticker was applied to all affected pens on 8/8/2025. The Resident Services Director labeled resident #11's Latanoprost bottle incorporating all five components of 2600.184.a. on 8/8/2025. Upon notification that resident #12's Eliquis was incorrectly labeled and the tabs were halved incorrectly by [redacted] the medication was wasted and a new supply was obtained from the home's house pharmacy the night delivery of 8/8/2025. Resident #12's Pravastatin bottle had a changed order label placed to reflect the current order from the MD on 8/8/2025.

To enhance currently compliant operations: Effective 8/11/2025, the Resident Services Director began education to the nurses and med techs on the components of 2600.184 and their role in compliance, specifically highlighting the requirement of the E-Mar matching identically with the pharmacy label, with an in-service completion date of 8/17/2025.

Effective 8/18/2025, the Director of Resident Services/designee will perform 3 audits per floor of the E-MARs aligning with pharmacy labels weekly x 12 and monthly x 3 to maintain ongoing compliance with the components of 2600.184. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

Update: After receiving corporate nursing consultation regarding medication related deficiencies, the suggestion was made to implement a daily redlining process similar to what occurs in skilled nursing. Effective 9/22/2025, the Resident Services Director will be educated on redlining new orders with a completion date of 9/22/2025. Moving forward, redlining will occur Monday through Friday with Saturday and Sunday being reviewed Monday mornings.

Licensee's Proposed Overall Completion Date: *10/01/2025* Not Implemented [redacted] - 12/1/25)

185a - Implement Storage Procedures

11. 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 #5 is ordered morphine concentrate 100mg/5ml (20mg/ml) oral solution – 0.25ml every 4 hours take only as needed for air hunger and severe pain. However, on 8/5/25 at 3:55 p.m., this medication was not available in the home.

Resident #7 is ordered Glucose 5GM tablet chewable – 3 tablets orally twice dally as needed for glucose less than 60. However, on 8/5/25 at 1:25 p.m., this medication was not available in the home. There was only a bottle of Glucose

185a - Implement Storage Procedures (continued)

tablets 4GM.

Resident #7 is ordered Glucagon 1MG/0.2mL solution prefilled syringe – 1mg subcutaneous daily as needed for blood glucose <55. On 8/5/25 at 1:50 p.m., this medication was not available in the home.

Resident #7 is ordered Erythromycin 5mg/gm – Instill 1 strip in both eyes as needed for one time a day at bedtime. On 8/5/25 at 1:50 p.m., this medication was not available in the home.

On 8/5/25 at 2:12 p.m., there was a multi-dose medication pack labeled for resident #12 for administration on 8/5/25 at 8:00 a.m. that had been altered and taped closed. The pack originally contained Amiodarone 200mg – Give 1 tablet by mouth once daily and Rexulti 05mg – give ½ tablet (0.25mg) by mouth once daily. According to staff person C, the administration of the Rexulti has been changed to evening. Because of this change, the Amiodarone is removed from the package and administered in the morning and the package taped and put back in medication cart so that the Rexulti can be administered in the evening. However, the altering of the package did not follow the Department's policy directive from January 2025. The package was torn across the upper left corner, there was no indication that the package was altered by a nurse.

Plan of Correction ***Accept [redacted] - 10/02/2025)***

In response to the violation on 8/8/2025 by the Department of Human Services Licensing, immediate action was taken by the Resident Services Director on 8/8/2025 to address resident #5's ordered morphine concentrate. After discussion with hospice an order was obtained to discontinue this medication due to non-use. Resident #7's Glucose 5GM tablet chewable tablets were ordered from pharmacy and the 4GM tablets were removed from the med cart on 8/8/2025. Resident #7's Glucagon was ordered from pharmacy on 8/8/2025.
Resident #7's Erythromycin 5mg/gm eye ointment was ordered 8/8/2025 from pharmacy and placed in med cart.
Resident #12's Rexulti was corrected by receiving a new packet from pharmacy on the next delivery. This medication was later discontinued by the doctor on 8/26/2025 and therefore subsequently removed from the med cart.

To enhance currently compliant operations: Effective 8/11/2025, the Resident Services Director began education to the nurses and med techs on the components of 2600.185.a and their role in compliance, specifically highlighting the requirement of the E-Mar matching identically with the pharmacy label as well as not altering medication packets, with an in-service completion date of 8/17/2025.

Effective 8/18/2025, the Director of Resident Services/designee will perform 3 audits per floor of the E-MARs and medications on the cart weekly x 12 and monthly x 3 to maintain ongoing compliance with the components of 2600.185.a. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

Update: After receiving corporate nursing consultation regarding medication related deficiencies, the suggestion was made to implement a daily redlining process similar to what occurs in skilled nursing. Effective 9/22/2025, the Resident Services Director will be educated on redlining new orders with a completion date of 9/22/2025. Moving forward, redlining will occur Monday through Friday with Saturday and Sunday being reviewed Monday mornings.

Licensee's Proposed Overall Completion Date: *10/01/2025* Not Implemented [redacted] 12/1/25)

187a - Medication Record

12. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

As of 1/6/25 resident #5 is ordered Metformin ER 500mg tablet extended-release oral – Take 2 tablets = 1000mg by mouth daily. However, the entry for this medication on the resident's August 2025 medication administration record (MAR) indicates -Metformin Hl ER oral tablet extended Release 24 hour 500mg – Give 1 tablet by mouth one time a day for DM.

The entry on resident #5's August 2025 MAR for Flonase Allergy Relief Nasal Suspension (Fluticasone Propionate) – 1 spray in both nostrils one time a day does not include the strength of the medication.

Resident #7 is ordered Fexofenadine HCl tablet 180mg orally – 1 tablet swallow whole with water; do not take with fruit juices. However, on 8/5/25 at 1:22 p.m., the entry for this medication on the resident's August 2025 medication administration record (MAR) only indicated Fexofenadine HCl oral tablet 180 mg – Give 1 tablet by mouth one time a day. The MAR did not include the special instructions.

Resident #7 is ordered Vitamin D3 1000 units – take 2 tablets daily. However, on 8/5/25 at 1:22 p.m., the entry for this medication on the resident's August 2025 MAR only indicated Cholecalciferol tablet 1000 unit – Give 2 tablet by mouth one time a day. The MAR did not indicate that this medication is also known as Vitamin D3.

Repeat Violation 5/20/24

Plan of Correction ***Accept [redacted] - 10/02/2025)***

In response to the violation on 8/8/2025 by the Department of Human Services Licensing, immediate action was taken on 8/8/2025 by the Resident Services Director to clarify the order for dosage strength on Resident #5's Flonase Allergy Relief Nasal Suspension (Fluticasone Propionate) with the physician and entered into the E-MAR. Resident #7's special instructions for Fexofenadine HCl tablet 180mg orally were added to the E-MAR as per order. Resident #7's E-MAR was updated to include instructions that Cholecalciferol is also known as Vitamin D3.

187a - Medication Record (continued)

To enhance currently compliant operations: Effective 8/11/2025, the Resident Services Director began education to the nurses and med techs on the components of 2600.187.a and their role in compliance, specifically highlighting the requirement of the E-Mar matching identically with the pharmacy label as well as incorporating any special instructions into the E-MAR when listed on bottle, with an in-service completion date of 8/17/2025.

Effective 8/18/2025, the Director of Resident Services/designee will perform 3 audits per floor of the E-MARs and medications on the cart weekly x 12 and monthly x 3 to maintain ongoing compliance with the components of 2600.187.a. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

Update: After receiving corporate nursing consultation regarding medication related deficiencies, the suggestion was made to implement a daily redlining process similar to what occurs in skilled nursing. Effective 9/22/2025, the Resident Services Director will be educated on redlining new orders with a completion date of 9/22/2025. Moving forward, redlining will occur Monday through Friday with Saturday and Sunday being reviewed Monday mornings.

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

Implemented [redacted] - 12/01/2025)

187b - Date/Time of Medication Admin.

13. 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 #7 is ordered Artificial tears 2-4 times daily. However, on 8/5/25 at 1:50 p.m., this medication was not available in the home. According to staff person C, [redacted] finished the bottle yesterday, ordered new drops at that time, and did not administer the eye drops to resident on 8/5/25 at 8:00 a.m. However, staff person C indicated on the resident's August 2025 medication administration record (MAR) that the drops were administered on 8/5/25 at 8:00 a.m.

Plan of Correction ***Accept [redacted] - 10/02/2025)***

In response to the violation on 8/8/2025 by the Department of Human Services Licensing, immediate action was taken, on 8/8/2025, by the Resident Services Director to ensure that resident #7's Artificial tears were delivered from pharmacy for the next dosage. Staff person C received educational counseling from the Resident Services Director on 8/11/2025 regarding the components of 2600.187.b as well as the home's medication administration policy which includes the 5 rights for medication administration.

To enhance currently compliant operations: Effective 8/11/2025, the Resident Services Director began education to the nurses and med techs on the components of 2600.187.b and their role in compliance, specifically highlighting the requirement of all meds needing to be available in the home regardless of whether the resident regularly or infrequently requests said medication and specifically highlighting the requirement for documentation to be completed at the time of administration, with an in-service completion date of 8/17/2025.

187b - Date/Time of Medication Admin. (continued)

Effective 8/18/2025, the Director of Resident Services/designee will perform 3 audits per floor of the E-MARs and medications on the cart weekly x 12 and monthly x 3 to maintain ongoing compliance with the components of 2600.187.b. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

Update: After receiving corporate nursing consultation regarding medication related deficiencies, the suggestion was made to implement a daily redlining process similar to what occurs in skilled nursing. Effective 9/22/2025, the Resident Services Director will be educated on redlining new orders with a completion date of 9/22/2025. Moving forward, redlining will occur Monday through Friday with Saturday and Sunday being reviewed Monday mornings.

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

Implemented [redacted] - 12/01/2025)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

As of 1/6/25 resident #5 is ordered Metformin ER 500mg tablet extended-release oral – Take 2 tablets = 1000mg by mouth daily. However, the entry for this medication on the resident's August 2025 medication administration record (MAR) indicates -Metformin Hl ER oral tablet extended Release 24 hour 500mg – Give 1 tablet by mouth one time a day for DM. The medication was signed of as only one tablet being administered from 8/1/25 – 8/5/25.

Resident #7 is ordered Artificial tears 2-4 times daily. However, on 8/5/25 at 1:50 p.m., this medication was not available in the home. According to staff person C, [redacted] finished the bottle yesterday, ordered new drops at that time, and did not administer the eye drops to resident on 8/5/25 at 8:00 a.m.

Resident #12 is ordered Eliquis 2.5mg twice daily. However, on 8/5/25 at approximately 2:15 p.m., there was a bottle of Eliquis 5mg tablets with pharmacy label indicating "take 1 tablet by mouth twice a day; "1/2 tab" was hand-written in marker on the label. The tablets in the bottle were cut in half. However, 5mg tablets of Bristol Myers Squibb/Pfizer Eliquis are not scored to be able to be cut in half evenly.

Plan of Correction ***Accept ([redacted] - 10/02/2025)***

In response to the violation on 8/8/2025 by the Department of Human Services Licensing, immediate action was taken on 8/8/2025 by the Resident Services Director to ensure that resident #7's Artificial tears were delivered from pharmacy for the next dosage. Staff person C received educational counseling on 8/11/2025 from the Resident Services Director regarding the components of 2600.187.d as well as the home's medication administration policy which includes the 5 rights for medication administration. Upon notification that resident #12's Eliquis was

187d - Follow Prescriber's Orders (continued)

incorrectly labeled and the tabs were halved incorrectly by family, the medication was wasted and a new supply was obtained from the home's house pharmacy.

To enhance currently compliant operations: Effective 8/11/2025, the Resident Services Director began education to the nurses and med techs on the components of 2600.187.d and their role in compliance, with an in-service completion date of 8/17/2025.

Effective 8/18/2025, the Director of Resident Services/designee will perform 3 audits per floor of the E-MARs and medications on the cart weekly x 12 and monthly x 3 to maintain ongoing compliance with the components of 2600.187.d. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

Update: After receiving corporate nursing consultation regarding medication related deficiencies, the suggestion was made to implement a daily redlining process similar to what occurs in skilled nursing. Effective 9/22/2025, the Resident Services Director will be educated on redlining new orders with a completion date of 9/22/2025. Moving forward, redlining will occur Monday through Friday with Saturday and Sunday being reviewed Monday mornings.

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

Implemented [redacted] - 12/01/2025)

225a - Assessment 15 Days

15. 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 #3's initial assessment completed [redacted]/24, indicates in Part III (page 2 of 12) for "Eating" that resident is coded "A = Independent." However, the Description of Service Need and Plan to Meet Service Need indicate that "Resident does have a history of pocketing food at previous facility." And that the home will "monitor eating for pocketing of food. Resident is on a mechanical soft diet."

As the result of a speech pathology consult and barium swallow on 6/17/25, resident #4 was recommended a "thin liquids, mechanical soft diet; maintain upright posture during/after eating for 30 mins, slow single presentation, small sips/bites, reduce distractions, encourage timely oral prep and swallow, alternate between small bites and sips of food/liquid, check mouth frequently for oral residue/pocketing Monitor for signs of aspiration: gurgly voice, throat clearing, upper respiratory infection, cough, pneumonia, right lower lobe infiltrates." However, resident #4's assessment completed [redacted]/24 was not updated to include this dietary change. The resident's assessment also was not updated when the resident was ordered a pureed diet upon discharge from the hospital on [redacted]/25.

Resident #5's initial assessment completed [redacted]/24, did not include the resident's need/use of a bedside mobility device to include:
** The specific need for the device;*
** The intended use and any risks associated with the use;*

225a - Assessment 15 Days (continued)

** The resident's ability to use the device safely for the purpose it was intended*
** Identification of the specific device to be used and whether a cover is required to meet FDA guidelines.*

Resident #12 initial assessment completed [redacted]/25, did not include the resident's need/use of a bedside mobility device to include:
** The specific need for the device(?);*
** The intended use and any risks associated with the use;*
** The resident's ability to use the device safely for the purpose it was intended*
** Identification of the specific device to be used and whether a cover is required to meet FDA guidelines.*

Plan of Correction ***Accept[redacted] - 10/02/2025)***

In response to the violation on 8/8/2025 by the Department of Human Services Licensing, immediate action was taken by the Resident Services Director to ensure that the resident assessment and support plans were updated for the residents as follows:

For Resident #3, no changes were made to the original assessment completed [redacted]/24, due to the chart being closed because of the resident's [redacted]/25. Resident #4's chart was updated on 8/11/2025 to include the dietary change of the recommendation for a "thin liquids, mechanical soft diet; maintain upright posture during/after eating for 30 mins, slow single presentation, small sips/bites, reduce distractions, encourage timely oral prep and swallow, alternate between small bites and sips of food/liquid, check mouth frequently for oral residue/pocketing Monitor for signs of aspiration: gurgly voice, throat clearing, upper respiratory infection, cough, pneumonia, right lower lobe infiltrates." The pureed diet was updated on an addendum followed by the update for the current order for mechanical soft. Resident #5's chart was updated on 8/11/2025 to include the resident's need/use of a bedside mobility device capturing:
** The specific need for the device;*
** The intended use and any risks associated with the use;*
** The resident's ability to use the device safely for the purpose it was intended*
** Identification of the specific device to be used and whether a cover is required to meet FDA guidelines.*
Resident #12's chart was updated on 8/11/2025 to include the resident's need/use of a bedside mobility device capturing the following:
** The specific need for the device;*
** The intended use and any risks associated with the use;*
** The resident's ability to use the device safely for the purpose it was intended*
** Identification of the specific device to be used and whether a cover is required to meet FDA guidelines.*

To enhance currently compliant operations: Effective 8/11/2025, the Resident Services Director began education to the nurses and med techs on the components of 2600.225.a and their role in compliance, specifically highlighting the changes in resident care that need reflected on the RASP, with an in-service completion date of 8/17/2025.

Additionally, in response to the deficiencies related to resident assessments and support plans, the Administrator implemented a daily clinical huddle process to include discussion from the nursing team on any new orders in the last 24 hours, any changes in condition or election of services, etc. that would affect the RASP. The Resident Services Director was educated on 9/15/2025 on the new process with a completion date of 9/15/2025.

Effective 8/18/2025, the Resident Services Director/designee will complete audits on two resident charts for six consecutive weeks until deficiency free to ensure the residents' evaluation and assessment diagnoses are accurately

225a - Assessment 15 Days (continued)

reflected, followed by the Resident Services Director/designee completing monthly audits of all resident's annual medical evaluations due in that month as well as all new resident move-ins in that corresponding month times 4 months, ensuring compliance at that time with 2600.225.a. In addition, the daily clinical huddle process that the Administrator implemented includes a daily review of changes in condition to ensure the information is then appropriately charted.

Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes. Results of the audits will be brought to the home's QM meetings for discussion, review, and suggestions. The home's next QM meeting is scheduled for October 7, 2025.

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

Implemented [redacted] - 12/01/2025)

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

Facility Information

Name: *SOUTHMINSTER PLACE* **License #:** *41593* **License Expiration:** *06/24/2026*

Address: *880 SOUTH MAIN STREET, WASHINGTON, PA 15301*

County: *WASHINGTON* **Region:** *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *PRESBYTERIAN SENIOR CARE INC*

Address: *880 SOUTH MAIN STREET, WASHINGTON, PA, 15301*

Phone: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *75* **Waking Staff:** *56*

Inspection Information

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

Reason: *Interim* **Exit Conference Date:** *10/27/2025*

Inspection Dates and Department Representative

10/27/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served:** *66*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *66*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *9* **Have Physical Disability:** *1*

Inspections / Reviews

10/27/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/15/2025*

Inspections / Reviews *(continued)*

11/17/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/26/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/29/2025*

12/01/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/26/2025*

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

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 11:30am, there was a red binder labeled Narcotic Count Sheets which included the controlled drug receipt record and pharmacy labels for the following residents setting on the unattended medication cart which was located in the hallway outside of the 2nd floor nurses' station (room [redacted]):

• Resident #1 – morphine sul sol 100/5ml – take 0.5ml (10mg) by mouth under the tongue every one hour as needed for severe pain/shortness of breath….

• Resident #2 - oxycodone 5mg tablet – Give ½ tablet (2.5mg) by every night and ½ tab q day prn pain

• Resident #3 – hydrocodone/APAP 5/325mg – 1 tablet by mouth every 8 hours as needed for pain.

• Resident #4 – oxycodone 5mg tablet – Give 1 tablet by mouth once daily at bedtime.

At 2:28 p.m. there was a white binder labeled Narcotic Count Sheets which included the controlled drug receipt record and pharmacy labels for the following residents setting on the unattended medication cart that was in the hallway between the 3rd floor kitchen and sitting room:

• Resident #5 – alprazolam 0.25mg tablet – Give 1 tablet by mouth once daily as needed for anxiety

• Resident #6 – lorazepam tab 0.5mg

• Resident #7 – diazepam 3mg ½ tab

• Resident #8 – hydrocodone/APAP 5-325mg tab - Give 1 tablet by mouth three times daily for 14 days

• Resident #9 – tramadol; 50mg – Give ½ tablet (25mg) by mouth every 8 hours as needed for severe pain

Plan of Correction ***Accept [redacted] - 11/17/2025)***

In response to the violation on 10/27/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken by the administrator to secure all narcotic count sheets binders in house and address the issue with each nurse assigned to each floor on 10/27/2025, discussing the non-compliance with the components of 2600.17. This deficiency was a current issue from the annual survey in which this facility is under a current plan of correction and actively auditing, but the narcotic count sheet binders were an oversight by the auditors, not realizing the contents of what was inside each binder. In order to correct this issue, this specific component has been added to the audits.

To enhance currently compliant operations:
Effective 10/27/2025, the Administrator and Resident Services Director began education to the nurses/med passers on the components of 2600.17 and their role in compliance, specifically noting the narcotic count sheets as well as increased awareness of any and all personal/protected information that might be accessible to others, with a completion date of 10/31/2025.

Effective 11/10/2025, the Administrator began to complete audits of the whole house daily x 5 and will follow with random audits throughout the house weekly x 4, then monthly x 3 to maintain ongoing compliance with the components of 2600.17. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

17 - Record Confidentiality (continued)

Results of the audits will be brought to the home's QM meeting for discussion, review, and suggestions. The home's next QM meeting has been scheduled for November 24, 2025.

Licensee's Proposed Overall Completion Date: *11/28/2025* Not Implemented [redacted] - 12/1/25)

184a - Resident's Meds Labeled

2. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #5 is ordered Xanax oral tablet 0.25mg – Give 1 tablet by mouth at bedtime AND Xanax oral tablet 0.25mg - Give 1 tablet by mouth as needed for anxiety daily during daytime. However, at 3:18 p.m., the only blister pack of this medication had a pharmacy label for Xanax 0.25mg – Give 1 tablet by mouth once daily as needed for anxiety. The label did not include the straight bedtime order.

Resident #10 is ordered Fexofenadine tablet 180mg - 1 tablet swallow whole with water; do not take with fruit juices. Once a day 30 day(s). At 2:31 p.m., the blister pack of this medication only indicated "Allergy relief" 180mg tabs – 1 tablet swallow whole with water; do not take with fruit juices; orally once a day 30 days.

Resident #10 is ordered Erythromycin 5mg/GM ophth ointment – Instill 1 strip in both eyes as needed one time a day at bedtime. However, the pharmacy label for this medication indicates Erythromycin 5mg/GM oint – apply ¼ inch strip to lower lid cul de sac. The label does not indicate if it is for one or both eyes.

Resident #11 is ordered Melatonin 3mg – Give 6mg by at bedtime. However, at 4:35 p.m., the pharmacy label for this medication indicated Melatonin 3mg – Take 2 tablets (6mg) by mouth at bedtime as needed. There was no "Directions changed" sticker on the bottle.

Plan of Correction ***Accept [redacted] - 11/17/2025)***

In response to the violation on 10/27/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken by the Resident Services Director (RSD) to correct the following:
Resident # 5 - On 10/27/2025 the RSD contacted the house pharmacy to order a separate card for the Xanax oral tablet 0.25mg – Give 1 tablet by mouth at bedtime prescription. The card was received on the next delivery 10/28/2025, resolving this issue.
Resident # 10 - On 10/27/2027, the RSD applied a directions change sticker to the Allergy relief tablet 180mg card, pointing team members to the order on the chart. The RSD also reached the pharmacy on 10/28/2025 to educate on the need for labeling from the pharmacy to exactly match the order. Finally, under "additional directions" within the order, the RSD added "same as Fexofenadine tablet 180mg" so that all med passers can identify appropriately.
For Resident #10's Erythromycin 5mg/GM ophth ointment, the RSD clarified and updated the order to reflect the

184a - Resident's Meds Labeled (continued)

need to apply "¼ inch strip to lower lid cul de sacs" (correcting the issue of reflecting placement in both eyes on the order). Finally, a directions change sticker was placed on the medication to point med passers to the need for placement in both eyes.
Resident #11 - On 10/27/2025, the RSD placed a Directions Changed sticker on the bottle of Melatonin 3mg.

To enhance currently compliant operations:

Effective 10/28/2025, the Resident Services Director (RSD) began education to the nurses/med passers on the components of 2600.184.a and their role in compliance, specifically noting that all medications within the med cart must align verbatim with the order as well as the EMAR and if they do not, a "Change Directions" sticker must be applied, with a completion date of 10/31/2025.

Effective 11/3/2025, the RSD began to complete audits of the whole house daily and will continue as such through completion of the whole house audit (currently ongoing). Upon completion of the whole house audits, the RSD/designee will complete random audits of 5 residents weekly x 4, then monthly ongoing to maintain compliance with the components of 2600.184.a. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Results of the audits will be brought to the home's QM meeting for discussion, review, and suggestions. The home's next QM meeting has been scheduled for November 24, 2025.

Licensee's Proposed Overall Completion Date: *11/28/2025* Not Implemented [redacted] - 12/1/25)

185a - Implement Storage Procedures

3. 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 #5 is ordered Refresh Tears ophthalmic solution (Carboxymethylcellulose Sodium (Ophth)) – Instill 1 drop in both eyes every 8 hours as needed for dry eyes. However, at 3:30 p.m., this medication was not available in the home.

Resident #10 is ordered Glucagon 1MG/0.2ML solution prefilled syringe – 1mg subcutaneous daily as needed for blood glucose <55. However, at 3:13 p.m., the medication present in the home for this need was Zegalogue (Dasiglucagon) 0.6mg/0.6ml – as directed subcutaneous daily as needed for hypoglycemia <50.

Plan of Correction ***Accept*** [redacted] ***- 11/17/2025)***

In response to the violation on 10/27/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken by the Resident Services Director (RSD) to correct the following:
Resident #5 - On 10/28/2025, the RSD began investigating orders within the chart noting that the original order was for "Artificial Tears - 1 drop in both eyes every 8 hours as needed." Upon that finding, the in-house pharmacy was contacted to fill the order for Artificial Tears.
Resident #10 - Upon notification of this issue, the RSD contacted the resident's external pharmacy and identified that per the pharmacy, the "Glucagon 1MG/0.2ML solution prefilled syringe – 1mg subcutaneous daily as needed for blood glucose <55" order was not covered by the resident's insurance plan. Per the external pharmacy, they contacted the resident's physician to request and order for Zegalogue (Dasiglucagon) 0.6mg/0.6ml – as directed

185a - Implement Storage Procedures (continued)

subcutaneous daily as needed for hypoglycemia <50, but neglected to notify our facility. The RSD requested the order be sent over and it now matches.

Effective 10/28/2025, the Resident Services Director (RSD) began education to the nurses/med passers on the components of 2600.185.a and their role in compliance, with a completion date of 10/31/2025.

Effective 11/3/2025, the RSD began to complete audits of the whole house daily and will continue as such through completion of the whole house audit (currently ongoing). Upon completion of the whole house audits, the RSD/designee will complete random audits of 5 residents weekly x 4, then monthly ongoing to maintain compliance with the components of 2600.185.a. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Results of the audits will be brought to the home's QM meeting for discussion, review, and suggestions. The home's next QM meeting has been scheduled for November 24, 2025.

Licensee's Proposed Overall Completion Date: *11/28/2025* Not Implemented [redacted] - 12/1/25)