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

November 19, 2025

[redacted]
FIVE STAR QUALITY CARE NS OPERATOR LLC
[redacted]
ATTN: LICENSING
[redacted]

RE: THE DEVON SENIOR LIVING
445 NORTH VALLEY FORGE ROAD
DEVON, PA, 19333
LICENSE/COC#: 13206

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/11/2025, 08/12/2025 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: *THE DEVON SENIOR LIVING* **License #**: *13206* **License Expiration**: *10/06/2025*

Address: *445 NORTH VALLEY FORGE ROAD, DEVON, PA 19333*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *FIVE STAR QUALITY CARE NS OPERATOR LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/26/2003* **Issued By**: *Commonwealth of PA, L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *64* **Waking Staff**: *48*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *08/12/2025*

Inspection Dates and Department Representative

08/11/2025 - On-Site: [redacted]

08/12/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served**: *42*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Bridges* **Capacity**: *26* **Residents Served**: *16*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *42*

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

Have Mobility Need: *22* **Have Physical Disability**: *1*

Inspections / Reviews

08/11/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/13/2025*

10/21/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/02/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/26/2025*

Inspections / Reviews *(continued)*

10/22/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/02/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/02/2025*

11/19/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/02/2025*

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

17 - Record Confidentiality

2. 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 [redacted], at 10:01am, an empty medication blister pack for Resident [redacted] was unlocked, unattended, and accessible on the side of the medication cart. The communication binder noting resident treatments and conditions were left unlocked, unattended, and accessible near the nurse's office.

Resident records, and medication logs were left unlocked, unattended and accessible at the nurses' station.

Plan of Correction ***Accept [redacted] - 10/21/2025)***

- *On 8/11/25, DHS Inspector observed an empty medication blister pack on the medication cart and the nursing office was unlocked and unsecured.*
- *At the time of this inspection, the medication blister pack was immediately discarded by the Healthcare Director.*
- *Healthcare Director/Designee monitored the medication carts and nursing office daily to ensure the door was locked until the lock was replaced.*
- *Nursing office door handle and lock were replaced by the Maintenance Director on 10/6/25 with a self-locking key-less entry coded door lock.*
- *Community nursing staff will only have the code to enter the nursing office.*
- *Outside agencies will need to have community nursing staff open the nursing office.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *All Department Managers were retrained on Regulation 2600.17 on 10/13/25 by the Administrator.*
- *Nursing staff will be retrained by the Healthcare Director by 10/31/25 on ensuring the medication carts and nursing door are locked at all times to ensure resident record confidentiality.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented [redacted] 11/19/2025)

25b - Contract Signatures

3. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted] for Resident [redacted] was not signed by the resident.

25b - Contract Signatures (continued)

Repeat Violation

Plan of Correction ***Accept - 10/21/2025)***

- *On 8/11/25, DHS Inspector discovered Resident resident-home contract not signed by the resident. The POA had signed the resident-home contract on 6/27/24.*
- *Upon notification of this deficiency, the resident-home contract was immediately signed by Resident with the Administrator.*
- *On 8/22/25, an audit of all resident files was conducted by the Regional Operations Director. Any resident-home contract that was not signed, was corrected with audit noted.*
- *On 9/5/25, the Business Office Manager was trained by the Administrator on Regulation 2600.25b, which includes use of a New Resident Checklist for ongoing compliance.*
- *On 9/19/25, the Business Office Manager responsible for ensuring all resident-home contracts are signed, was separated from employment. Upon hire of a new Business Office Manager, the Administrator will provide training on Regulation 25b, understanding that all resident-home contracts must be signed by the Administrator/designee, the Resident, and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees, on or before the date of admission.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Administrator will monitor monthly for compliance.*

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

Implemented (- 11/19/2025)

26a - Quality Management Plan

4. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home does not have a quality management plan.

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of inspection, the home did not have a quality management plan.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, the quality management plan was not located.*
- *On 8/26/25, the Administrator received Five Star Senior Living training on the quality management program.*
- *On 9/25/25, the Administrator trained all department managers on 2600.26a, ensuring they all understood the purpose of the plan.*
- *On 9/25/25, the Administrator held their first quality management meeting with all department managers. During this meeting, the team reviewed reportable incident and condition reporting procedures, complaints, staff person training, licensing violations and plans of correction. and Resident council. In addition, new resident & associate files were reviewed, as well as resident's annual assessments and support plans.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Beginning 9/25/25, a quality management meeting will be held monthly.*

26a - Quality Management Plan *(continued)*

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented (- 11/19/2025)

42b - Abuse

5. 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 who has a diagnosis of dementia and resides in the secured dementia care unit from the home on at approximately 4:00 pm. Residents were attending a weekly event held at the home. The event was held in the café room. To access the café room, residents and staff and must walk past the main exit and front desk waiting area. Due to the placement of the furniture in the lobby area, staff and residents must walk closer to the main exit door to reach the main hall of the home. Resident walked out the main exit door while staff were transporting residents to the secured dementia care unit. Staff did not know resident eloped until approximately 4:15 pm when the home received a call stating the resident was on the neighboring property. Staff person A immediately went to the neighboring property to retrieve the resident. Resident was found with a lump on their head and a swollen hand. Staff person A reported resident verbally stated they were "ok", Resident was sent to the hospital for further assessment.

Plan of Correction

Accept (- 10/21/2025)

- *On 7/9/25, Resident , an SDCU resident, was attending a musical event in the PC common area. At the end of the event, Resident wandered out of the community and was not located until a neighbor notified the community fifteen minutes later.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, information regarding this incident was difficult to obtain.*
- *On 7/10/25, the Healthcare Director re-screened Resident for elopement concerns. Resident scored "at risk" due to cognitive status. Resident support plan was updated accordingly.*
- *On 8/26/25, the Memory Care Director and Healthcare Director were trained by the Administrator on Wandering and Elopement, per the Five Star Senior Living policy.*
- *All staff were educated by 8/31/25 on the Older Adult Protective Services Act, Resident's Rights, and Mandatory*
  Reporting, provided by the PA Department of Aging "Learning Management System", as an initial corrective action. All staff were educated by the Administrator on 9/24/25 on OAPSA, Resident Rights, and Mandatory Reporting. Also on 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.
- *By 10/31/25, all SDCU residents will be re-screened for elopement concerns by the Healthcare Director. Any concerns found will be addressed through support plan.*
- *Administrator will monitor monthly for compliance.*

42b - Abuse *(continued)*

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented (- 11/19/2025)

54a - Direct Care Staff

6. Requirements

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

Description of Violation

Direct care staff person B and direct care staff person C, do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Repeat Violation

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of the inspection, direct care Staff Person B and Staff Person C did not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aid registry.*
- *Staff Person B, hired on 7/8/25, was terminated from employment on 8/8/25, prior to this inspection.*
- *Staff Person C, hired on 3/20/25, became a Licensed Practical Nurse on 7/18/25. The home failed to have practical nursing license on file. On 8/13/25, this license was obtained by the Administrator and is in Staff Person C personnel file.*
- *On 8/22/25, an audit of all associate files was conducted by the Regional Operations Director. Any direct care staff that did not possess a high school diploma/CNA license, had theirs obtained and placed in their employment file immediately. They were not permitted to provide direct care until the diploma was received.*
- *On 9/5/25, the Administrator trained all department managers on Regulation 2600.54a, Direct Care Staff.*
- *On 9/19/25, the Business Office Manager responsible for ensuring all direct care staff have a high school diploma/CNA license on file, was separated from employment. Upon hire of a new Business Office Manager, the Administrator will ensure to provide training on Regulation 2600.54a, Direct Care Staff, to them.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Beginning 10/1/25, any direct care staff associate hired must provide proof of high school diploma, GED, or active registry status prior to beginning employment.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/13/2025*

Implemented (- 11/19/2025)

65a - FS Orientation 1st Day

8. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.

65a FS Orientation 1st Day *(continued)*

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person E, whose first day of work was [redacted] did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Staff person F, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *In response to the violation on 8/11/25 by the Pennsylvania Bureau of Human Service Licensing, the Administrator took immediate action by creating a binder specifically for Agency Staff with an orientation checklist for the first 40 scheduled hours of training. If agency Staff Person E or Staff Person F returns to the facility, they will be trained on missing education prior to starting shift.*
- *On 8/22/25, the Regional Operations Director audited the associate & agency files to maintain ongoing compliance with*
  2600.65a to identify any gaps in training requirements for all current and new associates & agency staffing. Any associate who missed training will immediately receive proper training from designated trainer including educational handouts located in the binder.
- *On 9/5/25, the Business Office Manager was trained by the Administrator on Regulation 2600.65a, which includes use of a New Hire Checklist for ongoing compliance. Beginning, 9/5/25, any new hire associate must have this New Hire Checklist completed before permitted to work.*
- *On 9/19/25, the Business Office Manager responsible for ensuring all direct care staff FS Orientation 1st Day on file, was separated from employment. Upon hire of a new Business Office Manager, the Administrator will ensure to provide training on Regulation 2600.65a, to them.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Administrator will monitor monthly for compliance.*

65a - FS Orientation 1st Day *(continued)*

Licensee's Proposed Overall Completion Date: *10/13/2025*

Implemented (- 11/19/2025)

65e - 12 Hours Annual Training

9. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person G received only 3 hours of annual training in training year 2024.

Repeat Violation

Plan of Correction ***Accept (- 10/21/2025)***

- *In response to the violation on by the Pennsylvania Bureau of Human Service Licensing, the home failed to provide the inspector with the AdvanceU (Relias) 2024 transcript for Staff Person G. Staff Person G received 28.21 total hours of annual training in 2024.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, information regarding AdvanceU (Relias) was difficult to obtain.*
- *On 8/22/25, the Regional Operations Director audited the associate & agency files to maintain ongoing compliance with 2600.65e to identify any gaps in training requirements for all current and new associates & agency staffing. Any associate who missed training will immediately receive proper training from designated trainer including educational handouts located in the binder.*
- *On 9/5/25, the Business Office Manager was trained by the Administrator on Regulation 2600.65e, which includes use of the 2025 annual training plan for ongoing compliance.*
- *On 9/19/25, the Business Office Manager responsible for ensuring all required annual training is completed, was separated from employment. Upon hire of a new Business Office Manager, the Administrator will ensure to provide training on Regulation 2600.65e, to them.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/14/2025*

Implemented (- 11/19/2025)

65f - Training Topics

10. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.

65f - Training Topics *(continued)*

6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person G did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2024.

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, the home failed to*
  provide the inspector with the AdvanceU (Relias) 2024 transcript for Staff Person G. Staff Person G received 29.46 total hours of annual training in 2024. Please review attached transcript for details.
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, information regarding AdvanceU (Relias) was difficult to obtain.*
- *On 8/22/25, the Regional Operations Director audited the associate & agency files to maintain ongoing compliance with*
  2600.65f to identify any gaps in training requirements for all current and new associates & agency staffing. Any associate who missed training will immediately receive proper training from designated trainer including educational handouts located in the binder.
- *On 9/5/25, the Business Office Manager was re-trained on Regulation 2600.65f, which includes use of the 2025 annual training plan for ongoing compliance.*
- *On 9/19/25, the Business Office Manager responsible for ensuring all required annual training is completed, was separated from employment. Upon hire of a new Business Office Manager, the Administrator will ensure to provide training on Regulation 2600.65f, to them.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/14/2025*

Implemented ([redacted] - 11/19/2025)

65g - Annual Training Content

11. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

65g - Annual Training Content *(continued)*

2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person G did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year January 2024 to December 2024.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 10/22/2025)***

- *In response to the violation on [redacted] by the Pennsylvania Bureau of Human Service Licensing, the home failed to provide the inspector with the AdvanceU (Relias) 2024 transcript for Staff Person G. Staff Person G received falls and accident prevention training on 5/3/24, and new population training on 9/12/24. Staff Person G failed to receive fire safety training, emergency preparedness, and OAPSA training by the former Administrator, and is unable to correct.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, information regarding AdvanceU (Relias) was difficult to obtain.*
- *On 8/11/25, the Administrator trained Staff Person G on Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).*
- *On 8/22/25, the Regional Operations Director audited the associate & agency files to maintain ongoing compliance with*
  2600.65g to identify any gaps in training requirements for all current and new associates & agency staffing. Any associate who missed training will immediately receive proper training from designated trainer including educational handouts located in the binder.
- *On 9/5/25, the Business Office Manager was trained by the Administrator on Regulation 2600.65g, which includes use of the 2025 annual training plan for ongoing compliance.*
- *On 9/17/25, the Administrator trained Staff Person G on emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *On 9/19/25, the Business Office Manager responsible for ensuring all required annual training is completed, was separated from employment. Upon hire of a new Business Office Manager, the Administrator will ensure to provide training on Regulation 2600.65g, to them.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *On 10/22/25, all staff, including Staff Person G, will be trained by a fire safety expert for annual training requirement.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/27/2025*

Implemented ([redacted] - 11/19/2025)

65g Annual Training Content *(continued)*

65i - Training Record

12. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of training for Staff person G does not include length of training, these trainings include [redacted] and EOP Manual.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 10/22/2025)***

- *In response to the violation on 8/11/25 by the Pennsylvania Bureau of Human Service Licensing, the home failed to provide the inspector with the AdvanceU (Relias) 2024 transcript for Staff Person G. Staff Person G received 0.75 total hours on 5/3/24 of annual elopement training in 2024.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, information regarding AdvanceU (Relias) was difficult to obtain.*
- *The home is unable to correct the deficiency on Staff Person G's EOP Manual training as it was conducted in person in 2024 by the former Administrator.*
- *On 9/5/25, the Business Office Manager was trained by the Administrator on Regulation 2600.65i, which includes use of the 2025 annual training plan for ongoing compliance.*
- *On 9/17/25, Staff Person G was trained on the new Emergency Operations Manual by the Administrator.*
- *On 9/19/25, the Business Office Manager responsible for ensuring all required annual training is completed, was separated from employment. Upon hire of a new Business Office Manager, the Administrator will ensure to provide training on Regulation 2600.65i, to them.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/21/2025*

Implemented ([redacted] - 11/19/2025)

66a - Staff Training Plan

13. Requirements

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

Description of Violation

The home does not have a staff training plan for 2025.

Plan of Correction ***Accept ([redacted] - 10/22/2025)***

- *At the time of this inspection, the home was unable to present the 2025 annual training plan.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, information regarding this incident was difficult to obtain.*
- *On 8/13/25, the Administrator created a new 2025 training plan to map out any missing annual training to*

66a - Staff Training Plan (continued)

be conducted 9/25 through 12/25. By 1/1/26, the Administrator will have created a new 2026 and ongoing annual training plan(s) to comply with regulations.

- *On 8/22/25, the Regional Operations Director audited the associate & agency files to maintain ongoing compliance with*
  2600.66a to identify any gaps in training requirements for all current and new associates & agency staffing. Any associate who missed training will immediately receive proper training from designated trainer including educational handouts located in the binder.
- *On 9/5/25, the Business Office Manager was trained by the Administrator on Regulation 2600.66a, which includes use of the 2025 annual training plan for ongoing compliance.*
- *On 9/19/25, the Business Office Manager responsible for ensuring all required annual training is completed, was separated from employment. Upon hire of a new Business Office Manager, the Administrator will ensure to provide training on Regulation 2600.66a, to them.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/21/2025*

Implemented (- 11/19/2025)

81b - Resident Personal Equipment

14. 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

The enabler bar for Resident is not securely attached to the resident's bed.

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of the inspection, the home failed to ensure the enabler bar for Resident #4 was securely attached to the resident's bed.*
- *Upon notification of this deficiency, the enabler bar was removed from Resident #4's bed due to non-use.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.81b.*
- *On 9/11/25, the Regional Director of Operations and Regional Clinical Specialist audited all apartments for enabler bars.*
- *On 9/12/25, the Maintenance Director checked all bed enablers to ensure they were securely attached to the residents' beds.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *On 10/13/25, the Memory Care Director and Healthcare Director were trained by the Administrator on Regulation 2600.81b.*
- *On 10/23/25, the Administrator will remind all residents at resident council on the use of enabler bars.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/24/2025*

Implemented (- 11/19/2025)

82c - Locking Poisonous Materials

15. Requirements

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

Description of Violation

Ultimate Shampoo and body wash, with a manufacture's label indicating "Contact poison control if swallowed", was unlocked, unattended, and accessible to Resident [redacted] in the Secured Dementia Care Unit. Not all the residents of the home, including Resident [redacted] have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *At the time of the inspection, Ultimate Shampoo and body wash, with a manufacture's label indicating "Contact poison control if swallowed", was unlocked, unattended, and accessible to Resident [redacted] in the Secured Dementia Care Unit. Not all the residents of the home, including Resident [redacted] have been assessed capable of recognizing and using poisons safely.*
- *Upon notification of this deficiency, the Memory Care Director removed the above-mentioned items and returned them to the locked spa room to ensure resident safety.*
- *On 8/18/25, the Administrator audited the memory care apartments for four weeks to ensure poisonous materials were secure.*
- *On 8/20/25, the Administrator audited all SDCU apartments for safety risks.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.82c.*
- *On 8/26/25, the Memory Care Director was trained by the Administrator on Regulation 2600.82c.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *On 10/8/25, the Regional Healthcare Director screened all current SDCU residents for their ability to recognize poisonous materials, utilizing photographs of soap, shampoo and bleach to assess their knowledge of. BIMS will be re-screened for all residents by 10/30/25.*
- *Beginning 10/20/25, the Memory Care Director will audit the safety conditions weekly on environmental rounds.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/30/2025*

Implemented ([redacted] - 11/19/2025)

85a - Sanitary Conditions

16. Requirements

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

Description of Violation

On [redacted] at 9:27am, a condiment, red in color was spilled on the shelf in the refrigerator.

On [redacted] at 10:07am, a substance that appears to be blood or feces streaked the bottom shelf by the door in the spa room.

On [redacted] at 9:25a, the bathroom located in room 16 has no method to dry hands.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of the inspection, on 8/11/2025 at 9:27am, a condiment, red in color was spilled on the shelf in the refrigerator, a substance that appears to be blood or feces streaked the bottom shelf by the door in the spa room, and the bathroom located in room 16 has no method to dry hands.*
- *Upon notification of the deficiencies, the Housekeeping Supervisor immediately cleaned the condiment spilled in the refrigerator and the substance appearing on the shelving unit in the spa room on 8/11/25. On 8/12/25, upon notification of the missing paper towels, the Housekeeping Supervisor immediately replaced the towels.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.85a.*
- *On 8/26/25, the Memory Care Director was trained by the Administrator on Regulation 2600.85a.*
- *On 8/28/25, the housekeeping department was trained by the Administrator on Regulation 2600.85a. As there is an assigned housekeeper for the SDCU, they were trained to check the refrigerator/freezer, spa room and all apartments on daily housekeeping rounds.*
- *On 9/5/25, the Memory Care Manager audited the refrigerator/freezer and the spa room for 4 weeks to ensure sanitary conditions.*
- *On 9/5/25, the Administrator audited all SDCU apartments for a method to dry hands. No deficiencies noted.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *Beginning 10/20/25, the Memory Care Director will audit the sanitary conditions weekly on environmental rounds.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented (- 11/19/2025)

85e - Trash Outside Home

17. 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 at 9:49 am, there was trash scattered on the ground outside the dining room exit which included weathered cardboard boxes, an old rag, several cigar butts and cigarettes butts.

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of this inspection, on 8/11/2025 at 9:49 am, there was trash scattered on the ground outside the dining room exit which included weathered cardboard boxes, an old rag, several cigar butts and cigarettes butts.*
- *Upon notification of this deficiency, the Maintenance Director immediately cleaned up the above-mentioned items from the ground outside the dining room exit.*
- *Beginning 8/18/25, the Culinary Director audited that area to ensure it was clear from trash and debris. No concerns noted.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.85.*

85e - Trash Outside Home (continued)

- *On 8/26/25, the Memory Care Director was trained by the Administrator on Regulation 2600.85 by the Administrator.*
- *On 8/28/25, the Housekeeping and Maintenance teams were trained on Regulation 2600.85 by the Administrator.*
- *On 9/3/25, the Culinary team was trained by the Culinary Director on Regulation 2600.85. During this training, it was designated that the utility person scheduled each day will round this area when taking the trash to the dumpster.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/16/2025*

Implemented ([redacted] - 11/19/2025)

96a - First Aid Kit

18. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit located in the Secured Dementia Care Unit Bridges, did not include a breathing shield.

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *At the time of this inspection, the first aid kit located in the Secured Dementia Care Unit Bridges, did not include a breathing shield, however the other six first aid kits contained all required supplies.*
- *Upon notification of this deficiency, a face shield was placed in the SDCU first aid kit by the Life Enrichment Director.*
- *On 8/20/25, the Life Enrichment Director, responsible for first aid kits, was trained by the Administrator on Regulation 2600.86a.*
- *On 8/20/25, the Life Enrichment Director audited all of the first aid kits and found no further deficiencies, utilizing a new audit tool.*
- *Beginning 8/20/25, the Life Enrichment Director will audit all first aid kits monthly, ensuring each has all of the required supplies.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/14/2025*

Implemented ([redacted] - 11/19/2025)

101j3 - Bed/Linens/Pillows/Blankets

19. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

101j3 - Bed/Linens/Pillows/Blankets *(continued)*

Description of Violation

The bed for Resident [redacted] does not have sheets, blankets or pillowcase.

The bed for Resident [redacted] does not have sheets on the bed.

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *At the time of this inspection, the bed for Resident 3 does not have sheets, blankets or pillowcase. The bed for Resident 6 does not have sheets on the bed.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, information regarding this situation was difficult to obtain. The Administrator discovered on 8/12/25, that all SDCU beds are stripped on Tuesdays by Housekeeping and laundered. That practice was changed immediately on 8/12/25, by the Administrator, creating a weekly linen/laundry laundering schedule. All linen was replaced on Resident #3 and Resident #6 beds at the time of inspection by the Housekeeper.*
- *Beginning 8/18/25, the Administrator audited all SDCU apartments to ensure clean linens were present, for four weeks.*
- *On 8/19/25, all of the home apartments were audited by the Administrator/designee for multiple requirements. Documentation will be retained.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.101.*
- *On 8/28/25, the Housekeeping and Maintenance teams were trained by the Administrator on Regulation 2600.101.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *Beginning 10/20/25, the Memory Care Director will audit the linens weekly on environmental rounds.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/17/2025*

Implemented ([redacted] - 11/19/2025)

101j7 - Lighting/Operable Lamp

20. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

In bedroom [redacted], the bed located to the far right does not have access to a source of light that can be turned on/off at bedside.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *At the time of this inspection, in bedroom 16, the bed located to the far right does not have access to a source of light that can be turned on/off at bedside.*
- *Upon notification of this deficiency, the Maintenance Director placed a lamp in bedroom 16 to the far right.*
- *Beginning 8/18/25, the Administrator audited all SDCU apartments to ensure a source of light were present at each bedside, for four weeks.*

101j7 Lighting/Operable Lamp (continued)

- *On 8/19/25, all of the home apartments were audited by the Administrator/designee for multiple requirements. Documentation will be retained.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.101.*
- *On 8/28/25, the Housekeeping and Maintenance teams were trained by the Administrator on Regulation 2600.101.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Beginning 10/20/25, the Memory Care Director will audit the source of light at the beside weekly on environmental rounds.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/17/2025*

Implemented (- 11/19/2025)

102i - Soap Dispenser

21. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On in bedroom , there was no soap located in the bathroom.

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of this inspection, on 8/12/2025 in bedroom , there was no soap located in the bathroom.*
- *Upon notification of this deficiency, the Maintenance Director replenished the soap in the dispenser in bedroom 13.*
- *Beginning 8/18/25, the Administrator audited all SDCU apartments to ensure a soap was available in every SDCU bathroom.*
- *On 8/19/25, all of the home apartments were audited by the Administrator/designee for multiple requirements. Documentation will be retained.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.102.*
- *On 8/21/25, the Administrator purchased non toxic liquid soap, labeled each with resident name, and placed in every SDCU bathroom.*
- *On 8/28/25, the Housekeeping and Maintenance teams were trained by the Administrator on Regulation 2600.102.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Beginning 10/20/25, the Memory Care Director will audit the soap weekly on environmental rounds.*
- *By 10/31/25, new wall mounted hand dispensers will be installed in every SDCU bathroom containing non toxic soap.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented (- 11/19/2025)

103f Refrigerator/Freezer Temps

22. Requirements

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

Description of Violation

There was no thermometer in the freezer on the 3rd floor lounge.

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of this inspection, there was no thermometer in the freezer on the 3rd floor lounge.*
- *Upon notification of this deficiency, a thermometer was placed in the freezer on the 3rd floor lounge by the Life Enrichment Director.*
- *On 8/20/25, the Life Enrichment Director, responsible for observations of the personal care resident refrigerators/freezers for thermometers and food inspection, was trained by the Administrator on Regulation 2600.103.*
- *Beginning 9/8/25, the Life Enrichment Director audited all personal care refrigerator/freezers to ensure they were complaint with thermometers and food handling requirements, for four weeks.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *Beginning 10/1/25, the Life Enrichment Director will audit all personal care refrigerator/freezers, monthly, ensuring each has a thermometer and food is stored according to regulations.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/17/2025*

Implemented (- 11/19/2025)

103i Outdated Food

23. Requirements

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

Description of Violation

On , there were unlabeled, undated cans of cranberry sauce and biscuits in a plastic bag in the refrigerator located on the 3rd floor.

Repeat Violation

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of this inspection, on 8/11/2025, there were unlabeled, undated cans of cranberry sauce and biscuits in a plastic bag in the refrigerator located on the 3rd floor.*
- *Upon notification of this deficiency, the cranberry sauce and biscuits were discarded by the Life Enrichment Director.*
- *On 8/20/25, the Life Enrichment Director, responsible for observations of the personal care resident refrigerators/freezers for thermometers and food inspection, was trained by the Administrator on Regulation 2600.103.*
- *Beginning 9/8/25, the Life Enrichment Director audited all personal care refrigerator/freezers to ensure they were complaint with thermometers and food handling requirements, for four weeks.*

103i - Outdated Food (continued)

- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Beginning 10/1/25, the Life Enrichment Director will audit all personal care refrigerator/freezers, monthly, ensuring each has a thermometer and food is stored according to regulations.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/17/2025*

Implemented ([redacted] - 11/19/2025)

123b - Emergency Procedures Posted

25. Requirements

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

Description of Violation

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

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *At the time of this inspection, the home's emergency procedures are not posted in a conspicuous and public place in the home.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, there whereabouts of the emergency procedures was difficult to ascertain.*
- *On 8/12/25, the emergency procedures binder was returned to the entry lobby counter by the Administrator, which was located inside a cabinet in the lobby.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.123b.*
- *On 8/25/25, the Administrator created a new emergency procedures binder and submitted for review to the Tredyffrin Township Fire Department.*
- *On 9/17/25, the Administrator trained department managers on Regulation 2600.123b, emergency preparedness procedures and recognition and response to crises and emergency situations, utilizing the new emergency procedures binders.*
- *On 9/18/25, the new emergency procedures binder was placed in a conspicuous and public place in the lobby, as well as copies given to managers to have in the kitchen, memory care, physical therapy gym, and the healthcare areas.*
- *All staff were trained on by the Administrator on Regulation 2600.123b, and the new emergency procedures binder by 9/23/25.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented ([redacted] - 11/19/2025)

124 - Notice to Fire Department

26. Requirements

124 - Notice to Fire Department *(continued)*

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of this inspection, the home did not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, information regarding the written notification to fire officials was difficult to obtain.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.124.*
- *On 8/25/25, the Administrator notified Tredyffrin Township Fire Department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.*
- *Beginning 8/25/25, the Administrator/designee will notify the Tredyffrin Township Fire Department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency, monthly, or as needed should the census needs change.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented (- 11/19/2025)

131f - Fire Extinguisher Inspection

27. 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

On , The fire extinguisher located in the laundry room, near room 201 has not been inspected by a fire safety expert.

Repeat Violation

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of this inspection, the fire extinguisher located in the laundry room, near room 201 has not been inspected by a fire safety expert.*
- *During this inspection, the inspector did not notify the home that this extinguisher was not inspected by a fire safety expert. If they had, the home would have had the extinguisher inspected on 9/10/25, when Summit Fire Protection came to the home to certify two extinguishers that were identified on the 8/4/25 DHS inspection.*
- *On 8/26/25, the Administrator trained the Maintenance Director on regulation 2600.131f, Fire Extinguisher Inspection, including the use of a checklist to ensure all extinguishers are checked monthly.*

131f - Fire Extinguisher Inspection (continued)

- *Upon receipt of the Licensing Inspection Summary on 10/6/25, the Maintenance Director immediately replaced the fire extinguisher in the laundry room, near room 201 with an inspected spare extinguisher.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *On 10/13/25, Summit Fire Protection came to the home and re-certified all 45 fire extinguishers in the home.*
- *Beginning 11/1/25, the Maintenance Director will begin utilizing the new checklist while checking each extinguisher. The Maintenance Director will use this checklist monthly.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented ([redacted] - 11/19/2025)

132c - Fire Drill Records

28. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drill conducted on [redacted] does not include the routes used to evacuate.

The fire drill record for the face drill conducted on [redacted] did not include the specific time the fire drill was held.

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *At the time of this inspection, the fire drill record for the fire drill conducted on 1/9/2025 does not include the routes used to evacuate. The fire drill record for the face drill conducted on 6/26/2025 did not include the specific time the fire drill was held.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, information regarding the home's fire drills was difficult to obtain.*
- *The home failed to provide the department with the fire drill record that is provided by Fire Safety Solutions, the third-party provider used for fire drills.*
- *The fire drill conducted on 1/9/25 was not done by Fire Safety Solutions due to the fire panel being replaced. The Maintenance Director conducted this fire drill, without proper prior training and failed to include the routes used to evacuate. The fire drill conducted on 6/26/25 had the time of the fire drill written in military time.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.132. This was where the Administrator was informed that Fire Safety Solutions did not conduct the 1/9/25 fire drill.*
- *On 8/21/25, Fire Safety Solutions was contacted by the Administrator to ensure the official fire drill record, which is compliant, was provided to the home. Documentation is retained.*
- *Three fire drills have been held since this inspection, and the record is correct with exit routes used and time of the fire drills.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *All monthly fire drill reports will be reviewed by the Administrator for compliance.*

132c - Fire Drill Records *(continued)*

Licensee's Proposed Overall Completion Date: *10/16/2025*

Implemented (- 11/19/2025)

162e - Menu Changes

29. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On [redacted] red pepper soup was served instead of beef noodle soup as listed on the menu. No notice was provided to the residents in advance of the meal change.

Plan of Correction ***Accept (- 10/21/2025)***

- *On 8/11/25, red pepper soup was served instead of beef noodle soup as listed on the menu. No notice was provided to the residents in advance of the meal change.*
- *On 8/11/25, the meal substitution log was updated, but not the resident menus. The Culinary Director indicated to the inspector that the SYSCO truck did not deliver red peppers to make the soup that morning.*
- *On 8/18/25, the Culinary Director was retrained by the Administrator on Regulation 2600.162e, stressing the importance of notifying residents of a meal substitution.*
- *On 8/19/25, the home placed a large neon sandwich board at the entrance to the dining room that will inform residents of any changes, which is working well.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *On 10/8/25, the Culinary Director trained all culinary staff on Regulation 2600.162e, which included how to use the sandwich board and the substitution log.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/14/2025*

Implemented (- 11/19/2025)

181e - Capable to Self Administer

30. Requirements

2600.
181.e. To be considered capable to self-administer medications, a resident shall:
1. Be able to recognize and distinguish [redacted] medication.
2. Know how much medication is to be taken.
3. Know when medication is to be taken.

Description of Violation

Resident [redacted] self-administers medications to include [redacted] 3 times a day, [redacted] once a day and, [redacted] once a day. On [redacted] Resident [redacted] was unable to recognize and distinguish their medication, indicate how much medication they take, say when they take their medication.

181e - Capable to Self Administer *(continued)*

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of the inspection, resident self-administers medications to include 3 times a day, once a day and, once a day. On Resident was unable to recognize and distinguish their medication, indicate how much medication they take, say when they take their medication.*
- *On 8/12/25, with POA permission, the Healthcare Director removed all medications from Resident . A new assessment and support plan were obtained that the resident prefers to have staff administer medications.*
- *On 8/19/25, the Healthcare Director was trained on by the Administrator on Regulation 2600.181.*
- *On 9/18/25, all Med Techs were trained by the Healthcare Director of Regulation 2600.181.*
- *On 10/8/25, the Regional Clinical Specialist assessed all self-admin residents, no concerns noted. The Healthcare Director will perform q6 month assessments or as needed, beginning 10/25.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *Beginning 10/20/25, the Healthcare Director/designee will begin weekly MAR to cart audits.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/16/2025*

Implemented (- 11/19/2025)

183b - Meds and Syringes Locked

31. 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 at 9:03am, medication for Resident , and was unlocked, unattended, and accessible in the nurse's station.

Plan of Correction ***Accept (- 10/21/2025)***

- *On 8/12/25 at 903am, medication for Resident ad was unlocked, unattended and accessible n the nurses' station.*
- *Upon notification of this deficiency, on 8/12/25 the Healthcare Director immediately placed the above-mentioned medications in the locked medication cart.*
- *On 8/19/25, the Healthcare Director was trained by the Administrator on Regulation 2600.183.*
- *On 8/19/25 all medication carts were audited by Omnicare Pharmacy, our third-party provider.*
- *On 9/18/25 all Med Techs were trained by the Healthcare Director on Regulation 2600.183.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Beginning 10/20/25, the Healthcare Director/designee will begin weekly MAR to cart audits.*
- *By 10/31/25, all Direct Care Staff will be trained on 2600.183 by the Healthcare Director to ensure that all staff are aware of medications needing to be locked in the medication carts.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented (- 11/19/2025)

183b Meds and Syringes Locked *(continued)*

183d - Prescription Current

32. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted], [redacted], prescribed for Resident [redacted] was in the home's medication cart; however, the medication was discontinued on [redacted]

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *On 8/12/2025, [redacted] prescribed for Resident [redacted] was in the home's medication cart; however, the medication was discontinued on 7/20/2025.*
- *Upon notification of this deficiency, on 8/12/25 the Healthcare Director immediately removed the medication and discarded it appropriately.*
- *On 8/19/25 the Healthcare Director was trained by the Administrator on Regulation 2600.183.*
- *On 8/19/25 all medication carts were audited by Omnicare Pharmacy, our third party provider.*
- *On 9/18/25 all Med Techs were trained by the Healthcare Director on Regulation 2600.183.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Beginning 10/20/25, the Healthcare Director/designee will begin weekly cart audits.*
- *By 10/31/25, all Direct Care Staff will be trained on 2600.183 by the Healthcare Director.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented ([redacted] - 11/19/2025)

183e - Storing Medications

33. 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], one syringe of [redacted], prescribed for resident [redacted], was missing the cap. [redacted] was still in the syringe.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *On 8/12/2025, one syringe of [redacted] prescribed for resident [redacted], was missing the cap. Clear liquid was still in the syringe.*
- *Upon notification of this deficiency, on 8/12/25 the Healthcare Director immediately removed the medication and discarded it appropriately.*
- *On 8/19/25, the Healthcare Director was trained by the Administrator on Regulation 2600.183.*
- *On 8/19/25 all medication carts were audited by Omnicare Pharmacy, our third party provider.*

183e Storing Medications (continued)

- *On 9/18/25 all Med Techs were trained by the Healthcare Director on Regulation 2600.183.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Beginning 10/20/25, the Healthcare Director/designee will begin weekly MAR to cart audits.*
- *By 10/31/25, all Direct Care Staff will be trained on 2600.183 by the Healthcare Director to ensure that all staff are aware of medications needing to be locked in the medication carts.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented (- 11/19/2025)

185a - Implement Storage Procedures

34. 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

On at 8:05pm, the for Resident reads , this reading was not documented in the resident's medication administration record.

On at 8pm, the for Resident reads , this reading was documented in the resident's medication administration record as .

On , - Give 1 tablet every 24 hours as needed for Resident was not available in the home.

Repeat Violation

Plan of Correction ***Accept (- 10/21/2025)***

- *On 8/12/2025, on 8/9/2025 at 8:05pm, the glucometer for Resident reads , this reading was not documented in the resident's medication administration record. On 8/10/2025 at 8pm, the glucometer for Resident reads , this reading was documented in the resident's medication administration record as On 8/12/2025, Tablet- Give 1 tablet every 24 hours as needed for Resident 11 was not available in the home.*
- *Upon notification of this deficiency, on 8/12/25 the Healthcare Director immediately duplicated the MAR for Resident for that date on paper and had the medication technician document the reading. Also, on 8/12/25, the Healthcare Director immediately duplicated the MAR for Resident for that date on paper and had the medication technician correct the documentation with. Lastly, on 8/12/25, the Healthcare Director requested the Loperamide refill from Omnicare Pharmacy and it was received at the home on 8/13/25.*
- *On 8/19/25, the Healthcare Director was trained by the Administrator on Regulation 2600.185.*
- *On 8/19/25 all medication carts were audited by Omnicare Pharmacy, our third-party provider.*

185a Implement Storage Procedures (continued)

- *On 9/18/25 all Med Techs were trained by the Healthcare Director on Regulation 2600.185.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Beginning 10/17/25, the Healthcare Director/designee will audit glucometers three times per week for accurate readings, cleanliness, and MAR accuracy.*
- *Beginning 10/20/25, the Healthcare Director/designee will begin weekly MAR to cart audits.*
- *By 10/31/25, all Med Techs will have glucometer competency training by the Healthcare Director/designee.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented ([redacted] - 11/19/2025)

187a - Medication Record

35. 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

Resident[redacted] is prescribed [redacted]. However, resident[redacted] July 2025 medication administration record does not indicate dose.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *On 8/12/2025, Resident[redacted] is prescribed [redacted]. However, resident[redacted] July 2025 medication administration record does not indicate dose.*
- *Upon notification of this deficiency, on 8/12/25 the Healthcare Director immediately corrected the order to include the dosage.*
- *On 8/19/25, the Healthcare Director was trained by the Administrator on Regulation 2600.187.*

187a - Medication Record (continued)

- *On 8/19/25 all medication carts were audited by Omnicare Pharmacy, our third-party provider. Any supplemental medications missing dosage were corrected.*
- *On 9/18/25 all Med Techs were trained by the Healthcare Director on Regulation 2600.187, emphasizing the need to review medications accurately to include dosage.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *Beginning 10/20/25, the Healthcare Director/designee will begin weekly MAR to cart audits.*
- *By 10/31/25, all Direct Care Staff will be trained on 2600.187 by the Healthcare Director.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented ([redacted] - 11/19/2025)

187b - Date/Time of Medication Admin.

36. 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 [redacted] is prescribed [redacted], take once a day and [redacted] delayed release [redacted], take once a day. Resident [redacted]s July medication administration record does not include the initials of the staff person who administered [redacted] and [redacted] delayed release [redacted] on [redacted] at 12:00 pm.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *On 8/12/2025, Resident [redacted] is prescribed [redacted], take once a day and [redacted] oral capsule delayed release 15mg, take once a day. Resident [redacted] July medication administration record does not include the initials of the staff person who administered [redacted] and [redacted] delayed release [redacted] on 7/28/2025 at 12:00 pm.*
- *Upon notification of this deficiency, on 8/12/25 the Healthcare Director immediately duplicated the MAR for that date on paper and had the medication technician sign for administration.*
- *On 8/19/25, the Healthcare Director was trained by the Administrator on Regulation 2600.187.*
- *On 8/19/25 all medication carts were audited by Omnicare Pharmacy, our third-party provider.*
- *On 9/18/25 all Med Techs were trained by the Healthcare Director on Regulation 2600.187, emphasizing the need to ensure their initials are saved on administration.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *Beginning 10/20/25, the Healthcare Director/designee will begin weekly MAR to cart audits.*
- *By 10/31/25, all Direct Care Staff will be trained on 2600.187 by the Healthcare Director to ensure that all staff are aware of medications needing to be locked in the medication carts.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/31/2025*

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

Implemented (- 11/19/2025)

225a - Assessment 15 Days

37. 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 assessment, dated does not have a need for transferring in and out of bed. However, the resident requires an enabler for transferring in and out of bed.

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of the inspection, Resident s assessment, dated 1/26/2025, does not have a need for transferring in and out of bed. However, the resident requires an enabler for transferring in and out of bed.*
- *Upon notification of this deficiency, the enabler bar was removed from Resident #4's bed due to non-use.*
- *On 9/11/25, the Regional Director of Operations and Regional Clinical Specialist audited all apartments for enabler bars.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *On 9/30/25, the Healthcare Director was trained by the Administrator on Regulation 2600.225.*
- *On 10/13/25, the Healthcare Director reviewed all assessments and support plans to ensure enablers are documented, any updates needed will be made immediately.*
- *On 10/23/25, the Administrator will remind all residents at resident council on the use of enabler bars.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/24/2025*

Implemented (- 11/19/2025)

225c - Additional Assessment

38. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident s assessment, dated indicates the resident can self-administer medication without assistance. The resident's medical evaluation dated indicates the resident can self-administer with assistance to store medications in a safe place. There was no update to the assessment to reflect this need.

Repeat Violation

Plan of Correction ***Accept (- 10/21/2025)***

225c Additional Assessment (continued)

- *At the time of the inspection, Resident [redacted] assessment, dated 9/15/2024, indicates the resident can self administer medication without assistance. The resident's medical evaluation dated 2/20/25 indicates the resident can self administer with assistance to store medications in a safe place. There was no update to the 9/10/2024 assessment to reflect this need.*
- *On 8/12/25, with POA permission, the Healthcare Director removed all medications from Resident [redacted]. A new assessment and support plan were obtained that the resident prefers to have staff administer medications.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *On 9/30/25, the Healthcare Director was trained by the Administrator on Regulation 2600.225.*
- *On 10/8/25, the Regional Clinical Specialist assessed all self admin residents, no concerns noted. The Healthcare Director will perform q6 month assessments or as needed, beginning 10/25.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/16/2025*

Implemented ([redacted] - 11/19/2025)

227d - Support Plan Medical/Dental

39. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for Resident [redacted] dated [redacted] indicates the resident has a need for ambulating. The resident's support plan dated [redacted] does not document how this need will be met.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *At the time of the inspection, the assessment for Resident [redacted] dated 9/29/2024, indicates the resident has a need for ambulating. The resident's support plan dated 9/29/2024 does not document how this need will be met.*
- *Prior to receiving this licensing inspection summary, the department cited the home for the same deficiency on 9/4/25. At that time, immediate action was taken on 9/4/25 by the Healthcare Director completing an additional assessment due to the significant change in condition.*
- *Resident #12 was subsequently transferred to a SNF for sub acute rehabilitation on 9/5/25. An assessment and support plan was created when the resident returned from SNF on 9/30/25.*
- *An audit of all assessments and support plans was completed by the Regional Healthcare Specialist on 9/5/25. Non compliance will be documented on the medical evaluation by the Healthcare Director. The Healthcare Director will continue with monthly audits of all assessments and support plans.*
- *On 9/5/25, the Administrator trained all department managers on Regulation 225c, Additional Assessments. All department managers were given assessments to audit as part of this training.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*

227d Support Plan Medical/Dental (continued)

- *On 9/30/25, the Administrator retrained the Healthcare Director on Regulation 2600.225c, Additional Assessments. The Healthcare Director has a clear understanding on ensuring all assessments are completed upon need. Documentation shall be retained.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/16/2025*

Implemented (- 11/19/2025)

231e - No Objection Statement

41. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident was admitted to the Secure Dementia Care Unit (SDCU) on The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of this inspection, Resident was admitted to the Secure Dementia Care Unit (SDCU) on 6/30/2025. The home has no documentation that the resident and the resident's designated person have not objected to the admission.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, information regarding this was difficult to obtain.*
- *On 8/20/25, the Healthcare Director was trained by the Administrator on Regulation 2600.231c.*
- *On 8/26/25, the Memory Care Director was trained by the Administrator on Regulation 2600.231c.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all staff meeting.*
- *On 9/5/25, the Regional Director of Operations audited all SDCU financial files for No Objection Statements. If a file was missing a No Objection Statement, new ones were obtained. All statements were signed by the home, the resident and the resident's designated person on 9/16/25. The statements have been filed in each resident's financial file.*
- *When a new resident is admitted to the home, or a personal care resident is transferred to the SDCU, a signed No Objection Statement will be obtained by the Administrator at the time of resident home contract signing.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/14/2025*

Implemented (- 11/19/2025)

233b - Lock Manufacturer Statement

42. Requirements

2600.

233b - Lock Manufacturer Statement *(continued)*

233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:
1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The home does not have a statement from the manufacturer verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *At the time of inspection, the home does not have a statement from the manufacturer verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, the manufacturer statement was not located.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.233b. The Maintenance Director then reached out to Securitas Healthcare to obtain the statement.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *On 10/7/25, Securitas Healthcare emailed the manufacturer statement to the Maintenance Director.*
- *The manufacturer statement was printed and placed in the state readiness binder on 10/7/25 by the Administrator and will be made available to an inspector upon request.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented ([redacted] - 11/19/2025)

233c - Key-Locking Devices

43. Requirements

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

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the main exit leaving the Secure Dementia Care Unit (SDCU).

Plan of Correction ***Accept ([redacted] - 10/21/2025)***

- *At the time of this inspection, the directions for operating the home's locking mechanism are not conspicuously posted near the main exit leaving the Secure Dementia Care Unit (SDCU).*
- *On 8/13/25, the Maintenance Director posted the directions on the wall that had ben removed due to the hallway walls had been painted. The directions had been posted the week before during the DHS inspection on 8/4/25.*
- *On 8/20/25, the Maintenance Director was trained by the Administrator on Regulation 2600.233c.*
- *On 8/26/25, the Memory Care Director was trained by the Administrator on Regulation 2600.233c.*
- *On 9/5/25, the Memory Care Director audited all SDCU exits weekly for 4 weeks to ensure instructions were*

233c - Key-Locking Devices (continued)

posted near the doors entering and exiting the SDCU.

- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *Beginning 10/20/25, the Memory Care Director will audit the directions posted monthly on environmental rounds.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented ([redacted] - 11/19/2025)

236 - Staff Training

44. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person G, who works in the Secure Dementia Care Unit (SDCU) had only 3 hours of training in dementia care during the January 2024 to December 2024 training year.

Repeat Violation [redacted]

Plan of Correction ***Accept ([redacted] - 10/22/2025)***

- *In response to the violation on* [redacted] *by the Pennsylvania Bureau of Human Service Licensing, the home failed to provide the inspector with the AdvanceU (Relias) 2024 transcript for Staff Person G. Staff Person G received 7.75 total hours of annual dementia training in 2024, including the three hours in-person training.*
- *As the timing of this inspection was on the first day of the new Administrator beginning employment, information regarding AdvanceU (Relias) was difficult to obtain.*
- *On 8/22/25, the Regional Operations Director audited the associate & agency files to maintain ongoing compliance with*
  2600.236 to identify any gaps in training requirements for all current and new associates & agency staffing. Any associate who missed training will immediately receive proper training from designated trainer including educational handouts located in the binder.
- *On 8/26/25, the Memory Care Director was trained on Regulation 2600.236, which includes use of the 2025 annual dementia training plan for ongoing compliance. The Memory Care Director will provide any missing dementia training to direct care staff between 9/25 and 12/25.*
- *On 9/19/25, the Business Office Manager responsible for ensuring all required annual training is completed, was separated from employment. Upon hire of a new Business Office Manager, the Administrator will ensure to provide training on Regulation 2600.236, to them.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an all-staff meeting.*
- *By 1/1/26, the Administrator will have created a new 2026 and ongoing annual training plan(s) to comply with regulations for Staff Person G.*
- *Administrator will monitor monthly for compliance.*

236 - Staff Training (continued)

Licensee's Proposed Overall Completion Date: *10/21/2025*

Implemented (- 11/19/2025)

252 - Record Content

46. 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.
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 record does not include color of hair and color of eyes.

Plan of Correction ***Accept (- 10/21/2025)***

- *At the time of the inspection, Resident s record does not include color of hair and color of eyes.*
- *Upon notification of this deficiency, the Healthcare Director corrected the record by adding the color of hair and color of eyes.*
- *On 9/24/25, all staff were trained by the Administrator on the Regulatory Compliance Guide, as part of an*

252 - Record Content (continued)

all-staff meeting.

- *On 10/13/25, the Healthcare Director and Memory Care Director were trained by the Administrator on Regulation 2600.252.*
- *On 10/14/25, the Regional Healthcare Director audited all resident record and updated any record missing the data required under Regulation 252.*
- *Beginning 10/14/25, any resident that admits to the home will have their record updated immediately upon admission.*
- *Upon hire of a new Business Office Manager, the Administrator will ensure to provide training on Regulation 2600.252, to them.*
- *Administrator will monitor monthly for compliance.*

Licensee's Proposed Overall Completion Date: *10/14/2025*

Implemented ([redacted] - 11/19/2025)