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

October 21, 2025

[redacted] REGIONAL DIRECTOR
CA SENIOR VALLEY FORGE OPERATOR LLC
[redacted]

RE: REVELLE SENIOR LIVING KING OF PRUSSIA
350 GUTHRIE ROAD
KING OF PRUSSIA, PA, 19406
LICENSE/COC#: 14788

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/12/2025, 08/13/2025 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: *REVELLE SENIOR LIVING KING OF PRUSSIA* **License #**: *14788* **License Expiration**: *01/16/2026*

Address: *350 GUTHRIE ROAD, KING OF PRUSSIA, PA 19406*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *CA SENIOR VALLEY FORGE OPERATOR LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1*	**Date**: *04/29/2025*	**Issued By**: *Upper Merion Township*
Type: *I-2*	**Date**: *04/29/2025*	**Issued By**: *Upper Merion Township*
Type: *Other*	**Date**: *04/29/2025*	**Issued By**: *Upper Merion Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *90* **Waking Staff**: *68*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *08/13/2025*

Inspection Dates and Department Representative

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

08/13/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *128* **Residents Served**: *65*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *28* **Residents Served**: *16*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *65*

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

Have Mobility Need: *25* **Have Physical Disability**: *0*

Inspections / Reviews

08/12/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/19/2025*

Inspections / Reviews *(continued)*

09/30/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/02/2025*

10/02/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/20/2025*

10/21/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2025*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

On Wednesday 08/13/25, and between 07/20/25 through 07/29/25, no staff present in the kitchen were ServSafe certified. The PA Department of Agriculture Food Employee Certification Act, 3 Pa C.S.A. 6501 – 6510, effective January 22, 2011, requires one employee per licensed food facility to obtain a nationally recognized food manager certification. National exam programs are those that have been approved by ANSI using the Conference of Food Protection certified food protection manager standards. The Food Employee Certification Act requires one supervisory employee per food facility to obtain a food safety certification by taking an ANSI-CFP nationally recognized food safety class. The certified employee must be available during all hours of operation. The certified employee is the Person-in-Charge (PIC) when in the facility.

The ANSI National Accreditation Board maintains a list of nationally recognized food protection manager certification programs on their website. Completion of any of the MANAGER food protection certification programs will serve as a valid food employee certification for your facility. Different types of certification programs are available. It is your responsibility to ensure you are taking a MANAGEMENT course, NOT a food handler course. For a list of certification providers throughout Pennsylvania see course listings under publications.

Plan of Correction ***Accept ([redacted] - 09/29/2025)***

Revelle Senior Living KoP will comply with PA Department of Agriculture Food Employee Certification Act, 3 Pa C.S.A. 6501-6510, effective January 22, 2011, requiring 1 employee per licensed food facility to obtain a nationally recognized food manager certification. The Employee Certification Act also requires 1 supervisory employee per food facility to obtain a food safety certification by taking an ANSI-CFP national recognized food safety class. Certified employee must be available during all hours of operation.

On 9-28-2025, Revelle Senior Living enrolled the sous chef in the ServSafe Food Protection Manager certification course to ensure the required credentials were obtained. The sous chef successfully passed the certification examination on 9-8-2025 and the certificate is now posted on the dietary bulletin board located in the Kitchen. The Dining Room Lead will also be enrolled into the ServSafe Food Protection Manager certification course and certification will be completed by October 8, 2025.

On 8-14-2025, the Executive Chef and Sous Chef were inserviced by the Residence Director on Regulation 2600.28. Documentation and participation in this inservice is kept in the employee training file.
An audit tool has been developed to document all dietary employees with their ServSafe completion dates. The Executive Chef/ designee will also record certification Expiraton dates on this audit form to facilitate timely recertification. Once an employee is certified, a copy of their certificate will be posted on the dietary bulletin board in the kitchen.

The Executive Chef/designee will oversee the re-enrollment of dietary employees into a ServSafe program prior to the certification expiration date. The Executive Chef will review outcomes of this process during the Quality Assurance

18 - Compliance With Laws (continued)

Meeting scheduled for October 16, 2025. Any issues or concerns will be discussed at the meeting and procedure changes made accordingly. The Executive Chef will be responsible for overall compliance with the regulation.

Licensee's Proposed Overall Completion Date: *10/20/2025*

Implemented (- 10/21/2025)

28e - Death of a Resident

2. Requirements

2600.
28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #1 passed away on Resident #1's personal belongings were removed from their room on However, a refund for the amount of the difference between any payments made and the cost of elder care provided to the resident prior to their passing was not issued until

Plan of Correction ***Accept (- 09/29/2025)***

Revelle Senior Living will ensure that residents are billed only for the nights they actually reside in the community. In the event that a refund is warranted due to discharge or transfer, it will be processed and issued within 30 days.

On 8/21/2025, The Business Office Director completed a comprehensive review of all administrative files related to discharged residents. This review verified that all residents who were entitled to a refund had the home office notified. Additionally, the Business Office Director verified the check processing dates, noting that while copies of cleared checks are not immediately available until they clear the bank, the dates of issuance have been confirmed.

The Business Office Director implemented a comprehensive Discharge Tracking Log on 8/22/2025, to ensure timely and accurate processing of resident refunds. The log includes columns for Resident's Name, Date of Discharge, whether a refund is due, the date of when the refund request was forwarded to the home office and the date on the check. The log will be updated by the Business Office Director/designee as information becomes available for each discharged resident. The Business Office Director/designee will review the log on a weekly basis and will follow up with the home office to confirm the status and issuance date of any outstanding refund checks. In addition, on 8-25-2025 the provisions of 2600.28c along with the specific timeframes referenced in 2600.28a were reviewed in detail by the Executive Director with the Business Office Director to reinforce the importance of adhering to all refund timelines.

Outcomes of the Discharge Tracking log and date of refund will be discussed by the Business Office Director at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions if necessary to the procedure will be discussed at that time. The Business Office Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

Implemented (- 10/21/2025)

42x - Safeguard

3. Requirements

2600.
42.x. A resident has the right to a system to safeguard a resident's money and property.

Description of Violation

The home has started installing a locking cabinet in each of the resident's rooms. As 8/12/2025, only seven of the 58 personal care and memory care occupied rooms have been completed. The remaining rooms do not have a system to safeguard the residents' belongings.
Six of the seven locking cabinets installed use the same key. Without additional restrictions, (key control logs, limited access to keys...) this is not an adequate system for safeguarding resident possessions.

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

Revelle Senior Living will ensure that each resident has a system to safeguard their personal property and valuables. For residents in the Memory Care unit, each room is equipped with a locking cabinet designated for storing their personal belongings and valuables.
An audit of all resident rooms was conducted by the Residence Director on July 15, 16 and 17th. This audit confirmed, that apart from the Memory Care Unit, no other resident rooms had locking devices supplied by the community available to secure valuables and personal items. Key installation was started on 7-31-2025.

On 9-18-2025, The Maintenance Director was in serviced by the Residence Director on regulation 2600.42x. Training participation documentation has been filed in the Employee Training Record. Each week, the Maintenance Director/designee will complete the installation of drawer locks in 3 resident rooms. For any room where installing a locked drawer isn't feasible, the community will instead provide a locked storage box. In either case, one key will be given to the resident, and the other key will be securely stored in the community's locked key box. Occupied rooms have been prioritized first for lock installation. Once all the occupied rooms are completed, the project will move onto unoccupied rooms. In order to track progress, the Maintenance Director has developed a log to outline each unit's status and completion. To ensure individualized security, each lock is secured with its own distinct key. On key will not open every lock.

Outcomes of the lock installation and provision of locked boxes will be discussed by the Maintenance Director/Designee at the Quality Assurance Meeting scheduled for 10-16-2025. The Maintenance Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

51 - Criminal Background Check

4. Requirements

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

Description of Violation

Staff person A hired [redacted] did not have a criminal background check requested until [redacted]

51 - Criminal Background Check (continued)

Repeat Violation: 01/30/25

Plan of Correction ***Accept (- 09/30/2025)***

Note: Revelle Senior Living was transitioned to new ownership on February 6, 2025

Revelle Senior Living KoP will comply with 2600.51. Criminal History Checks and Hiring [policies shall be in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S> & 10225.101 – 10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults). Staff person A Hire Date: 1-20-2025 did not have a criminal background check requested until 3-5-2025.

On August 15, 18 and 19, the Business Office Director completed an audit of all background checks for current employees. This audit compared the employee date of hire to the date of the Criminal Record Background Check. As a result of this review, the audit confirmed that all employees hired after the date of transition 2-6-2025, have background checks that are compliant with the regulatory timeframe.

Beginning August 20, 2025, the Business Office Director/designee will continue to complete the audit and update the form for each newly hired employee. The audit tool includes the employee's name, date of hire and date of Criminal Record Background Check completion. Staff, who are no longer employed at Revelle, will have their name removed from the audit form. This audit will be ongoing, and no new hire will be entered into the community's orientation program without verification from the Business Office Director of a completed background check. On August 20, 2025, The Residence Director inserviced the Business Office Director relative to regulation 2600.51 and the community's established process for auditing the background checks.

Outcomes of the Criminal Record Background Check Audit will be discussed by the Business Office Director/designee at the Quality Assurance Meeting Scheduled for 10-16-2025. Any revisions, if necessary, to the procedure will be discussed at that time. The Business Office Director will be responsible for ongoing compliance with this regulation.

Licensee's Proposed Overall Completion Date: *10/20/2025*

Implemented (- 10/21/2025)

63a - First Aid/CPR Training

5. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On Monday 08/11/25, from 5:30 PM to 7:00 PM and from 7:00 PM to 11:00 PM, 65 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On Monday 07/14/25, from 4:30 PM to 11:00 PM, 65 residents were present in the home. During this time no staff persons present in the home were certified in first aid, obstructed airway techniques and CPR.

Plan of Correction ***Accept (- 09/30/2025)***

To ensure that staff persons receive proper training to respond to an emergency situation, Revelle Senior Living will

63a - First Aid/CPR Training (continued)

have at least 1 staff person present in the community at all times for every 50 residents who is trained in first aid, certified in obstructed airway techniques and CPR.

On 8/14/2025, the Health Care Director conducted an audit of First Aid, CPR and Obstructed Airway certifications for current staff. Following this audit, the Health Care Director developed a spread sheet and documented each certified staff member along with their job position, certification date and expiration date. The required 1:50 staff to resident ratio of certified staff is now compliant with regulation 2600.63a.

To ensure the required 1:50 staff to resident ratio of certified staff present in the community at all times, beginning August 21, 2025, the Community Health Care Director, who is a certified instructor (Heartsaver, First Aid, CPR AED), has scheduled ongoing First Aid, CPR and Obstructed Airway training sessions. Additional dates continue to be added as necessary. Current Direct Care Staff and ancillary staff have the opportunity to participate in these scheduled trainings. Following each training, the Business Office Director/designee will update the audit form to reflect the current status of each direct care staff person and individual certificates of completion will be filed in the First Aid/CPR Binder located in the Business Office Director's Office. The CPR/First Aid and Obstructed Airway Audit Form will be reviewed monthly by the Business Office Director/designee. The Business Office Director/designee will notify the Health Care Director via email of any staff whose certification is within 1 month of expiring so that a retraining date can be scheduled. For all new hires, the Business Office Director will ensure that their certifications (if available and current) are copied and filed in the CPR/First Aid binder. In addition, any new hire's name, department and date of certification expiration (if available) will be added to the Audit Form. Beginning 9/21/2025, the Health Care Coordinator/designee will make a notation with the letter "C" on the Nursing schedules for all employees in the nursing department that are CPR/First Aid and Obstructed Airway certifications. Any issues that are identified, as a result of the scheduling will be corrected with the Health Services Coordinator for immediate correction. On 9/21/2025, both the Business Office Director and the Health Services Coordinator were inserviced relative to regulation 2600.63a. Discussion also included the auditing process of the certifications by the Business Office Director and the notation of the letter "C" on the Nursing schedules by the Health Care Coordinator/designee signifying CPR/First Aid and Obstructed Airway Certification.

Outcomes of the monthly review will be discussed by the Business Office Director/Designee at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary to the procedure will be discussed at that time. The Health Care Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

64c - Annual Training

6. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person [redacted] the home's administrator, completed 32.50 hours of Department-approved training in training year 2024; however 22.50 of those hours were completed online.

64c - Annual Training (continued)

Repeat Violation: 10/28/24, et. al.

Plan of Correction ***Accept (- 09/30/2025)***

An administrator will have at least 24 hours of annual training relating to the job duties. The Administrator may complete up to 12 of the 24 hours of training online. For the training year January 1, 2024, through December 31, 2024, the Residence Director had 32.5 credit hours in total. However, only 11 of those credit hours were in-person training.

The Residence Director conducted an audit of the annual training hours Beginning January 1, 2025, to current date. The audit identified 3 credit hours have been online.

The Residence Director currently uses a Personal Care Home Administrator Credit Form. 2 columns have been added: one for In-person and one for online training. As each training is completed, the Residence Director will place a check mark in the appropriate column to indicate the training method. The Residence Director will review this form on the first of each month to ensure the method of inservice training and adequate training hours are compliant with the regulation. Beginning 8/14/2025, the Business Office Director will review the Residence Director's Personal Care Home Administrator Credit Form quarterly to ensure adequate training hours are obtained. Any issues identified during the monthly audit will be corrected by the Residence Director.

Outcomes of the Personal Care Home Administrator Credit Form will be reviewed by the Residence Director at the Quality Assurance Meeting scheduled for 10-16-2025. The Residence Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

Implemented (- 10/21/2025)

65a - FS Orientation 1st Day

7. Requirements

2600.

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

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

Description of Violation

Staff person A, whose first day of work was , 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

65a - FS Orientation 1st Day (continued)

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 until [redacted]

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will comply with regulation 2600.65a and ensure that prior to or during the first workday, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers will have an orientation in general fire safety and emergency preparedness that includes the subject areas in 2600.65a 1-7. Staff person A, first day of work was [redacted]. [redacted] *did not receive* [redacted] *Fire Safety training until* [redacted] *An audit of all staff orientation files revealed that Staff person A did not have* [redacted] *Fire Safety training. Once identified, Staff person A received* [redacted] *training and the date of training was documented on the form.*

Beginning 8-18-2025 and ending on 8-20-2025, the Residence Director and the Business Office Director used the Employee Credentialing Tracking Form and each current employee's file to review all current employees' initial training records related to the subject areas specified in 2600.65a 1-7. Following this audit, any employee identified with omitted, or no evidence of the required training was provided with training from the Maintenance Director. Upon completion of the training, the Maintenance Director signed and documented the current date on the form. The training documentation was placed in the employee's file. All current employees now have documented evidence of having received training as outlined in 2600.65a 1-7.

As is the current procedure in this community, the Maintenance Director/designee provides the orientation as outlined in 2600.65a 1-7. Time is incorporated into each new hire's first day orientation to ensure this training is completed as per regulation for both timeframe and topic. To make certain all training topics included in 2600.65a 1-7 are completed prior to or on the first day of work, the Business Office Director/designee will review the new hire training form before the end of their workday. If training topics included in 2600.65a 1-7 have been omitted, the Business Office Director/designee will notify the Maintenance Director/designee to provide the necessary training. This procedure will be ongoing for each new hire. The completed training form will then be verified by the Business Office Director/designee, and the date of completion will be recorded on the Employee Credentialing Tracking Form (1st day Training Column). The Business Office Director received training from the Residence Director on 8-20-2025 to review regulation 2600.65a and discuss the established process.

Outcomes of the Employee Tracking Form – (1st Day Training Verification) will be reviewed by the Business Office Director/designee at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary, to the procedure will be discussed at that time. The Business Office Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

65b - Rights/Abuse 40 Hours

8. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.

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

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

Description of Violation

Staff person A completed [redacted] 40th scheduled work hour in January 2025. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions until [redacted]

Repeat Violation: 05/01/25, et. al.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes: (1) Resident Rights (2) Emergency Medical Plan (3) Mandatory Reporting of Abuse and Neglect under OAPSA (4) Reporting of reportable incidents and conditions. 1 staff person with a hire date of [redacted] had the requirements of 2600.65b completed on [redacted] Note: Legend Senior Living transferred to a new owner on February 6, 2025.

Following an audit conducted by the Residence Director and Business Office Director, on June 13, 2025, it was identified that staff person A had not received the required training on the topics specified in 2600.65b. Once the omission was identified, the training was provided by the applicable Department Head/designee and the form signed and dated on [redacted] A follow-up re-review of this audit was conducted on August 18, 2025, by the Business Office Director, and it confirmed that all employees who previously missed training on these topics have now received the required training.

Beginning 9-1-2025, for all new hires, the Business Office Director/designee will review each new employee's training form, prior to the completion of the 40 scheduled working hours timeframe. Any training items that are noted to be incomplete will have the training topic(s) provided immediately and before the 40 scheduled hours timeframe expires, by the applicable Department Head/designee. Completed training will be verified by the Business Office Director/designee and a date of completion will be recorded in the training column on the Employee Credentialing Tracking Form. This procedure will be ongoing for all new hires. The Business Office Director received training from the Residence Director on 8-20-2025 to review regulation 2600.65b and to discuss the established process.

Outcomes of the Employee Credentialing Tracking Form (Training Verification column) will be discussed by the Business Office Director/Designee at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary to this procedure will be discussed at that time. The Business Office Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

65d - Initial Direct Care Training

9. Requirements

65d - Initial Direct Care Training *(continued)*

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. Infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person C, hired on [redacted] began providing unsupervised ADL services in [redacted]. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Repeat Violation: 05/01/25, et. al.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Direct Care staff employed at Revelle Senior Living will not provide unsupervised ADL services until completion of 2600.65d 1-3 and all its provisions. Staff Person C, whose CNA registration had expired and had no Direct Care Training Course and Competency Test Training Certificate was immediately removed from the Resident Care Aide schedule. Staff Person C completed [redacted] Direct Care Training Course and Competency Test on 8-15-2025 and was returned to the Resident Care Aide Schedule.

On 8-18-2025, the Business Office Director conducted a re-audit of all active Direct Care Staff employee files to confirm the presence of the Direct Care Training and Competency Test Certification or active registry status on the PA nurse Aide registry. The audit confirmed that there were no issues identified.

To ensure that the approved Direct Care Training Course and Competency Test Certification or active registry status on the PA Nurse Aide registry credentialing documents are present in each Direct Care Staff employee file, upon hire, beginning 8-20-2025, the Business Office Director/designee will be responsible for verifying the necessary credentialing has been obtained. A notation will be entered in the Direct Care Certificate Column on the Employee Credentialing Tracking Form to verify the presence of the of the Direct Care Training Course and Competency Test Certification or active registry status on the PA Nurse Aide registry. No new hire will be entered into the

65d - Initial Direct Care Training (continued)

community orientation program without the Direct Care Training and Competency Test Certification or verification of active registry status on the PA Nurse Aide registry. The Business Office Director received training from the Residence Director on 8-20-2025 to review regulation 2600.65d and to discuss the established process.

Outcomes of the Employee Credentialing Tracking Form will be discussed by the Business Office Director/Designee at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary, to this procedure will be discussed at that time. The Business Office Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

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.
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 C 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, and safe management techniques during training year 2024.

Direct care staff person D did not receive training in medication self-administration training or safe management techniques during training year 2024.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that annual training for Direct Care Staff will include the topics as outlined in regulation 2600.65f (1-7). Staff persons C and D, did not have their 2024 annual training completed. Staff person C 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, and safe management techniques. Staff person C will be inserviced by the Health Services Coordinator by 9-22-2025 on the aforementioned topics. Staff person D did not receive medication self administration training or safe management techniques training for 2024. Staff person D will be inserviced by the Health Services Coordinator by 9-22-2025 on the aforementioned topics.

65f - Training Topics (continued)

Revelle Senior Living was transitioned to new ownership on February 6, 2025. It was confirmed by the Business Office Director that that 2024 annual training records for staff persons C and D are not available in the community.

The current staff training plan is scheduled from February 2025 through December 2025 and includes all training topics as outlined in 2600.65f (1-7). Attendance is mandatory for all staff. Those staff absent due to PTO, will be trained upon their return to the community by their Department Head Director/designee. All staff are required to sign the Training Log binder as confirmation of their attendance at the inservice training. Beginning 9-1-2025, The Business Office Director/designee will review the Training Log binder x1 per week for the next 2 months to identify any concerns with staff attendance. Any issues identified during the weekly review will be corrected immediately with the staff person involved. Ongoing issues with staff person non-compliance will result in a disciplinary action up to and including termination. On 8-20-2025, the Residence Director reviewed regulation 2600.65f with the Business Office Director and the established auditing process for training records.

Outcomes of the weekly review of the Training Log Binder and timeframes for additional auditing will be discussed by the Residence Director/designee at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary, to the procedure will be discussed at that time. The Residence Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
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 C 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 or falls and accident prevention during training year 2024.

Staff person D 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 during training year 2024.

65g - Annual Training Content (continued)

Repeat Violation: 10/28/24, et. al.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteer be trained annually on all topics as outlined in 2600.65g. Staff person C and Staff person D did not have their 2024 annual training on file in the community.

Revelle Senior Living was transitioned to new ownership on February 6, 2025. It was confirmed by the Business Office Director that the 2024 annual training records for staff persons C and D are not available in the community. Staff person C received fire safety training on 8-27-2025, and staff person D will receive fire safety training by 9-18-2025. 2025 Fire Safety training, completed by a fire safety expert is scheduled for all staff on 9/18/2025.

The current staff training plan is scheduled from February 2025 through December 2025 and includes all training topics as outlined in 2600.65g(1-6). Attendance is mandatory for all staff. Those staff absent due to PTO, will be trained upon their return to the community by their Department Head /designee. All staff are required to sign the Training Log binder as confirmation of their attendance at the training. Beginning 9-1-2025, the Residence Director/designee will review the Training Log binder x1 per week for the next 2 months to identify any concerns with staff participation and attendance. Any issues identified during the weekly review will be corrected immediately with the staff person involved. Ongoing issues with staff person non-compliance will result in a disciplinary action up to and including termination. The Business Office Director received training from the Residence Director on 8-20-2025 to review regulation 2600.65g and to discuss the established process.

Outcomes of the weekly review of the Training Log Binder and the timeframe for further audits will be discussed by the Residence Director/designee at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary, to the procedure will be discussed at that time. The Residence Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

85a - Sanitary Conditions

12. Requirements

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

Description of Violation

On 08/12/25, at approximately 10:15 AM, the commode on top of resident #2's toilet had urine inside the chamber pot and on the seat. The resident was not in the room at the time.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living is committed to maintaining a sanitary environment throughout the community. It was observed that Resident 2's toilet had urine inside the chamber pot and on the seat. On 8-12-2025, the Assistant Healthcare Director immediately cleaned the chamber pot and toilet seat.

On August 19, 2025, the Executive Director, conducted a thorough review of the of the secured dementia care unit using the Memory Care Environmental Audit Tool. No additional issues were identified during this review.

On September 18, 2025, the Executive Director amended the Memory Care Environmental Audit Tool to include a specific item "Are residents' bathrooms clean and in sanitary condition?" Beginning 9-18-2025, this audit will continue to be completed 3x/week for x2 months by the Assistant Health Care Director/designee. Any identified issues will be promptly addressed, and the housekeeping team will be notified as needed. Beginning 8-25-2025, all Direct Care staff and housekeeping staff will receive in service training led by either the Health Care Director/Residence Director/Maintenance Director or designee on the importance of maintaining sanitation within the community. This training will emphasize minimizing the risk of resident illness via sanitation, preventing rodent and insect infestation and insuring a dignified living environment for all residents. For issues requiring additional attention or equipment, staff will be informed to contact the Concierge for input of information to the Maintenance Director through the TELS system. (The Equipment Life Cycle System)

Outcomes of the Environmental audits will be reviewed by the Assistant Health Care Director at the Quality Assurance Meeting scheduled for October 16, 2025. Any revisions, if necessary to this procedure will be discussed at that time. The Assistant Health Care Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

85d - Trash Receptacles

13. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 08/13/25, at approximately 4:00 PM, there were three partially full, uncovered, unattended trash cans in the main kitchen; by the entrance door, the dishwasher area and in front of the walk-in refrigerator.

Repeat Violation: 1/30/2025

85d - Trash Receptacles *(continued)*

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that all trash in the kitchens and bathroom shall be kept in covered trash containers that prevent the penetration of insects and rodents. Trash containers in the kitchen, identified as being without lids immediately had the lids placed back on by the Sous Chef.

An audit of the entire kitchen was conducted on 8/14/2025 by the Sous Chef, no further issues with covered trash containers were identified.

Beginning 8-14-2025, all dietary staff will be inserviced by the Executive Chef on the importance of covered trash containers.
Topics for discussion will include:
1. Covering trash cans to prevent the spread of disease
2. Minimize the risk of insect and rodent infestations via covered trash containers
3. The removal of lids for trash containers in kitchen areas when they are actively in use, i.e. clean up or food preparation.
Any staff person on PTO, will be inserviced by the Executive Chef/designee upon their return to the Community.
Beginning 8/15/2025, a trash container and use of lids audit in dietary will be conducted by the Executive Chef/Designee, 3x daily for 2 weeks, then 2x daily for 2 weeks then 1x daily for 2 weeks. Any issues identified as a result of this audit
will be discussed with the staff person involved. Continued non-compliance will result in disciplinary action up to and including termination.

Outcomes of the trash receptacle lid audit will be discussed by the Executive Chef/designee at the Quality Assurance Meeting scheduled for October 16, 2025. Any revisions to the process will be discussed at that time. The Executive Chef will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

85e - Trash Outside Home

14. 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 08/13/25, at approximately 4:30 PM, the home's dumpsters in the garage/trash area, were not covered.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will keep all trash outside the home in covered containers that prevent the penetration of insects and rodents. On notification, the lid to the trash container which was found open was immediately closed by the Maintenance Director.

The other trash container lid was closed.

85e - Trash Outside Home (continued)

Beginning 8/20/2025, all housekeeping and maintenance departments will receive inservice training by the Maintenance Director on the proper use of covered trash containers. Discussion will include the following topics: 1.) Ensuring lids on trash containers are in place and securely fastened 2.) Using lids to reduce the risk of pest infestation and to avoid attracting animals. 3.) Containment of trash to minimize the risk of pest issues inside the community. Any staff person on PTO will be inserviced by the Maintenance Director upon their return to the community.

Beginning 8/20/2025, and continuing until further notice, exterior building and grounds inspections will be conducted daily by the Residence Director/designee. The Residence Director/designee will document all issues on the Building and Grounds Inspection Form. Any issues identified will be either immediately corrected or when notified by the reviewer, logged in the TELS system for attention and repair by the Concierge.

Outcomes of the Building and Grounds Inspection Forms will be discussed by the Residence Director at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions to this procedure will be discussed at that time. The Maintenance Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

95 - Furniture and Equipment

15. Requirements

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

Description of Violation

The exterior door, where the home maintains their recycling bins, was broken and laying on the ground leaving the recycle bins visible from the street.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that furniture and equipment accessible to residents is clean, free of hazards and in good repair. The gate, located near the recyclable bins is in need of repair. Estimates for repair obtained and repair work to begin on the gate on or before 9/23/2025.

On 8-14-2025, utilizing the Safety Inspection Checklist, an audit of the interior and exterior of the community was completed by the Residence Director. Any issues identified were immediately corrected. Any issue that could not be corrected immediately was logged into the Tels System for attention and repair.

Beginning 8-20-2025, all Maintenance and housekeeping staff will be inserviced by the Maintenance Director/designee on ensuring that all furniture and equipment accessible to residents is clean, hazard- free and in good repair. Emphasis will be placed on the following points:
1) Maintaining community furniture and equipment in good repair and free from hazards helps to ensure sanitary conditions and reduces the risk of resident injury while items are in use.

95 - Furniture and Equipment (continued)

2) Any identified maintenance or housekeeping issues should be entered into the TELS system (The Equipment Lifecycle Management System) for repair and attention. Upon notification, the Concierge will enter the information into the TELS system to notify the Maintenance Director of maintenance/housekeeping issue.

In order to ensure compliance and the safety of staff and residents, beginning 8-20-2025, the Residence Director/designee will complete the Safety Checklist 5 days/wk for 1 month followed by 3days/wk for 1 month. Additional timeframes to be determined by the Quality Assurance team. Outcomes of the Safety Inspection Checklist will be discussed by the Maintenance Director/designee at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions to this procedure will be discussed at that time. The Maintenance Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

100a - Exterior - Free of Hazards

16. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The ground by the recycling bins was littered with shards of glass possibly from a broken mirror that was being discarded.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will maintain the exterior of the community free from hazards and in good repair. Following notification, the broken glass near the recyclable bins was immediately cleared by the Maintenance Assistant and disposed of safely.

On 8-14-2025, the Residence Director conducted a comprehensive audit of the community's exterior and grounds using the Building and Grounds Inspection form. Any issues identified were addressed and immediately corrected by the Residence Director.

Beginning 8-20-2025, maintenance and housekeeping staff will be inserviced by the Maintenance Director on the importance of maintaining the community's exterior and grounds that are free from hazards and in good repair. The training will emphasize the following points:
1. Ensuring that the community's exterior and grounds are in good repair and free from hazards will reduce the risk of a resident injury or death when they are outdoors
2. Minimizes the risk of injuries to residents during outdoor recreational activities or in the event of an evacuation.
3. Entering any identified maintenance and housekeeping issues in the TELS System (The Equipment Lifecycle System) for repair and follow-up via the Concierge Desk.
Until further notice, beginning 8-18-2025, daily exterior building and grounds inspections will be conducted daily and outcomes documented on the Building and Grounds Inspection Form by the Residence Director/Designee. Any

100a - Exterior - Free of Hazards (continued)

issues identified will be immediately corrected or documented by the Concierge Desk in the TELS system for attention and repair.

Outcomes of the Building and Grounds Inspection Forms will be discussed by the Residence Director at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions to this procedure will be discussed at that time. The Maintenance Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

103f - Refrigerator/Freezer Temps

17. 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

On 08/13/25, at 4:06 PM, the temperature of the "line bamboree" / refrigerated prep table in the main kitchen was 43 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that all food requiring refrigeration be stored at or below 40 F and frozen food will be kept at 0F. Thermometers will be kept in all refrigerators and freezers to monitor temperatures. At the time of inspection on August 13, 2025, the refrigerated prep table registered a temperature of 44F. As a corrective measure, all contents were removed from the refrigerated prep table and the unit was taken out of service. The refrigerated prep table was then monitored 3x daily over a 3-day period with recorded temperatures ranging from 36 to 40F. After confirming stable temperatures, the refrigerated prep table was returned to service. Additionally, all cooks were trained by the Executive Chef during the 8-18-2025 all dietary inservice on the importance of keeping the refrigerator door closed when not actively in use.

All freezers and refrigerators in the Dietary Department and Bistro were observed for temperature readings by the Residence Director on 8-14-2025. Observation identified that a thermometer is present and the temperature readings on the refrigerator and freezers were all within range. Beginning August 18, 2025, all dietary staff was inserviced by the Executive Chef on the temperature requirements and daily documentation on the Temperature Reading Log form for refrigerators and freezers. Emphasis was placed on actions to be taken if a temperature reading does not meet the temperature requirement. In addition, all dietary staff was advised to close the refrigerator/freezer doors when not actively in use. Beginning 8-18-2025, in order to ensure compliance, the Executive Chef/Sous Chef/Designee will audit the temperature readings on all refrigerators and freezers in the kitchen and bistro 3x/week weekly for 2 months.

Outcomes of the Daily Temperature Reading Log Form and continued timeframes for auditing will be reviewed and discussed by the Executive Chef/designee at the Quality Assurance Meeting scheduled for October 16, 2025. The Executive Chef will have responsibility for ongoing compliance.

103f - Refrigerator/Freezer Temps *(continued)*

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

103i - Outdated Food

18. Requirements

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

Description of Violation

There were several unlabeled, undated items in the "line freezer" in the main kitchen including a bag of hamburger patties, a bag of chicken fingers, a bag of french fries, a bag of sweet potato french fries and a bag of sausage links.

Repeat Violation: 01/30/25

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

In order to ensure that food is safe for use, Revelle Senior Living will not use foods past the expiration date on the label. Food that is not labeled will be discarded. There were several unlabeled, undated items in the line freezer in the kitchen including a bag of hamburger patties, chicken fingers, french fries, sweet potato french fries and sausage links. All unlabeled/undated items were discarded by the Sous Chef 8-13-2025.

On 8-14-2025 at 10am, the Residence Director conducted a thorough audit of the kitchen. During this inspection, any food items that were found to be stored without a label or lacking a date were to be removed and discarded. An unlabeled and undated small pitcher of milk was identified in the refrigerator and immediately disposed of.

Beginning 8-14-2025, the Executive Chef has been providing inservicing to all Dietary Staff in accordance with regulation 2600.103. This training emphasized the importance of labeling and dating food items ensuring that all food items are safe for use and consumption. In addition, staff has been instructed on identifying and handling food spoilage and understanding "use by" dates for both fresh and processed foods. Any staff not present at the inservice due to PTO will be inserviced upon return to the community.

Beginning 8-20-2025, The Executive Chef/designee will conduct an expiration date and labeling audit 3x/week for 4 weeks and then 2x/week for 4 weeks. During these audits, any food items found without a label or expiration date will be immediately discarded. Results from these audits as well as any adjustments made to the auditing schedule will be reviewed by the Executive Chef/designee at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary to this procedure will be reviewed at that time. The Executive Chef will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

107c - Food/Water 3 Day Supply

19. Requirements

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

Description of Violation

On 08/13/25, the home served 63 residents, requiring 189 gallons of emergency drinking water. However, the home had zero (0) gallons of emergency water. The home does not have a contract with a local bottled water supplier that includes delivery of emergency food and water. Additionally, the home's emergency food was insufficient to feed the 63 residents for a three day period. The home had three boxes of freeze dried meals each containing one breakfast meal and two dinners for 25 people.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will maintain at least a 3-day supply of nonperishable food and drinking water for residents. Total licensed occupancy of community is 128.

As of today, the community's occupancy is 75 residents, requiring a total of 675 meals for a 3-day period. The Executive Chef placed an order on August 18, 2025, for 4 Emergency Food Kits. (each kit provides 274 meals) A total of 1096 meals are now available for use in the community. Water is stored on the premises in quantities of 1 gallon of water per person for a 3-day period. Based on an occupancy of 75 residents, a total of 225 gallons of water is needed. Currently, 300 gallons of water are available in the community for distribution as needed. On 8-18-2025, the Community Executive Chef and Sous Chef were inserviced by the Residence Director regarding 2600.107c. Inservice participation documents are filed in each staff person's training file.

To ensure sufficient quantities of emergency food and water, beginning September 1, 2025, the emergency food and water supply will be audited monthly by the Residence Director/designee. The current inventory of food and water is posted in the emergency supply room.

The Residence Director/designee will review the community occupancy monthly along with the number of meals and water available in the community at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary, to this procedure will be discussed at that time. The Residence Director is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

141a - Medical Evaluation

20. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

141a - Medical Evaluation *(continued)*

Description of Violation

The medical evaluation for resident #3 was not completed within 60 days prior to admission or within 30 days after admission of the resident. Resident #3's date of admission is [redacted], the resident's initial medical evaluation is dated [redacted].

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that a resident has a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on the form specified by the Department, within 60 days prior to admission or within 30 days after admission. Resident 3 admission date was [redacted] and the resident's initial evaluation was dated [redacted] Note: This community transitioned to Legend Senior Living on February 6, 2025.

On 8-15-2025, the Assistant Health Care Director conducted an audit of all current resident files, recording the move-in date and initial medical evaluation dates onto the Chart Audit form. Once completed, the Chart Audit form was reviewed by both the Assistant Health Care Director and the Health Care Director. As a result of this audit, any medical evaluations found to be out of compliance with regulatory timeframes will have a document attached to the non-compliant medical evaluation in the resident's chart, indicating that the noncompliance was identified during the audit.

Prior to move in, Revelle Senior Living requires that each resident's medical evaluation be fully completed by a physician, physician assistant or certified registered nurse practitioner. After receiving the completed medical evaluation, the Health Care Director or Assistant Heath Care Director will review the medical evaluation to verify all required information is provided. Following the review, the medical evaluation completion date will be documented on the Chart Audit form, and the potential resident will be provided with a move in date. This audit process was started 8/18/2025. To ensure consistent implementation of this process, on 8-18-2025, the Residence Director reviewed this procedure and inserviced the Assistant Health Care Director and the Health Care Director on regulation 2600.141a.

Outcomes of the Chart Audit form will be discussed by the Health Care Director/Assistant Health Care Director at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary to the procedure will be discussed at that time. The Health Care Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

141a - Medical Evaluation *(continued)*

Implemented (- 10/21/2025)

141b1 - Annual Medical Evaluation

21. Requirements

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

Description of Violation

Resident #4's most recent medical evaluation was completed on The resident's previous medical evaluation was completed on

Resident #5's most recent medical evaluation was completed on . The resident's previous medical evaluation was completed on

Repeat Violation: 05/01/25, et. al., 03/31/25, and 10/28/24, et. al.

Plan of Correction ***Accept (- 09/30/2025)***

Revelle Senior Living will ensure that at least annually, a resident has a medical evaluation completed by a physician, physician's assistant or certified registered nurse practitioner documented on the form specified by the Department. Resident 4's most recent medical evaluation was completed on Resident 4's previous medical evaluation was completed on . Resident 5's most recent medical evaluation was completed on The resident's previous medical evaluation was completed on

Beginning 8-16-2025, the Assistant Health Care Director conducted an audit of all current resident files, recording the move-in date and annual medical evaluation dates on the Chart Audit form. Following a review of the Chart Audit form by both the Assistant Health Care Director and the Health Care Director, any annual medical evaluations found to be out of compliance with regulatory timeframes will have a document attached to the non-compliant medical evaluation, indicating that the noncompliance was identified during the audit.

Using the information recorded on the completed Chart Audit form, the Assistant Health Care Director and the Health Care Director will review the medical evaluation dates weekly. Beginning 8-18-2025, the Health Care Director or Assistant Health Care Director will coordinate the necessary appointment with the physician/family in advance of the due date and arrange for a date/time for a physical exam to be performed and the required medical evaluation to be completed. Once the medical evaluation is completed, the Assistant Health Care Director or the Health Care Director will review the medical evaluation for completeness of information and document the medical evaluation completion date on the Chart Audit form. To ensure consistent implementation of the procedure, on 8-18-2025, the Residence Director inserviced both the Assistant Health Care Director and the Health Care Director on the procedure for obtaining Annual Medical Evaluations and regulation 2600.141b1.

Outcomes of the Chart Audit form and medical evaluation compliance will be discussed by the Health Care Director or Assistant Health Care Director at the Quality Assurance Meeting scheduled for 10-16-2025. Revisions, if necessary to the procedure will be discussed at that time. The Health Care Director will be responsible for ongoing compliance.

141b1 - Annual Medical Evaluation *(continued)*

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

181f - Record of Medication

22. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 08/13/25, resident #6's record did not include a current list of medications. The list in the resident's record did not include Tramadol HCL 50 MG Tab - Take 1/2 tablet by mouth every 6 hours as needed for severe pain for up to 12 doses.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure the resident's record includes a current list of prescriptions, CAM and OTC medication for each resident who is self-administering their medications. On 8-18-2025, resident 6's record did not include a current list of medications. The list in the resident's record did not include Tramadol HCL 50 MG Tab – take ½ tablet by mouth every 6 hours as needed for severe pain for up to 12 doses. On 8/14/2025, the Health Services Director contacted resident 6's physician and an updated medication list was obtained. The medication list was forwarded to the community pharmacy provider for profiling. The resident's record now includes a current list of prescriptions.

Beginning 8-20-2025 and continuing to the audit is complete, each resident who self-administers their medications will have their resident record reviewed by the Health Care Director/designee to ensure that a current list of prescriptions is available and included. If a current list of medications cannot be located in the resident's record, the Health Services Director/designee in conjunction with the resident and/or resident's responsible party will contact the attending physician to obtain an accurate, current, medication list. The medication list will then be forwarded to the community pharmacy provider for profiling and inclusion in the resident's medical record.

By 9-22-2025, all residents who self-administer medications will receive correspondence from the Health Care Director providing the direction to notify the Nursing Dept. of all new, changed and discontinued orders, including prescription and non-prescription i.e. (over-the-counter) medications including vitamins, nutritional supplements, herbals and topical agents. Correspondence will emphasize the importance of ensuring that staff is prepared to provide accurate information regarding a resident's medication in the event of a medical emergency or if a resident becomes incapacitated. Beginning 9/1/2025, during the quarterly assessment for all residents who self-administer, the Health Care Director/designee will compare the list of medications currently located in the resident record to the resident's actual medications. In conjunction with the resident and resident's physician, any discrepancies identified by the Health Care Director/designee during the quarterly assessment will be corrected and the resident medication list updated by the physician. In addition, the Health Care Director/designee will re-educate the resident and/or resident's responsible party concerning notification of the Nursing Department for any new, changed or discontinued medication orders. On 9/1/2025, The Health Care Director implemented a Quarterly Assessment Tracking Tool in order to track the current date of the Quarterly Assessment and the next due date. The Health Care Director will be responsible for updating the audit tool, including and removing resident names as applicable.

Outcomes of the quarterly assessment review will be discussed by the Health Care Director/Designee at the Quality

181f - Record of Medication (continued)

Assurance Meeting scheduled for 10-16-2025. The Health Care Director is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

Implemented (- 10/21/2025)

182b - Prescription Medication

23. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 07/27/25, at 12:00 PM, staff person D administered medications to residents to include the following; Amlodipine Tab 2.5 MG, Escitalopram Tab 10 MG, Losartan Pot Tab 100 MG, among others. Staff person D is not in compliance with the Department approved medication administration program. Staff person D passed the initial training on [redacted] but has not completed the annual practicum to maintain [redacted] medication administration certification.

On 07/24/25, at 08:00 PM, staff person E administered medications to residents to include the following; Olopatadine Dro 0.1% (Pataday) and Mupirocin Oin 2% (Bactoban). Staff person E is not in compliance with the Department approved medication administration program. Staff person E passed the initial training on [redacted] but has not completed an annual practicum since [redacted] to maintain [redacted] medication administration certification.

Plan of Correction ***Accept (- 09/30/2025)***

Revelle Senior Living will ensure that prescription medication that is not self-administered by a resident is administered by qualified individuals in accordance with 2600.182(b) 1-4. Staff persons D and E were immediately removed from their Medication Technician roles pending the completion of the required documentation. Staff person D had [redacted] annual practicum completed and Staff person E was enrolled in the Medication Administration course and was re-certified and observed on 8-15-2025. Staff person D was returned to the Medication Technician Role on 8-15-2025 and Staff person E was returned to the Medication Technician role on 8-16-2025.

To ensure that medication is administered safely and in accordance with best practice by trained professionals, on 8-13-2025 and 8-14-2025, the Regional Health Care Director Specialist conducted a thorough review of each current Medication Technician's qualifications to verify that each staff person has the proper credentialing and are current with observations and practicums. All Medication Technicians are current with their Medication Technician observations and annual practicums.

On 8-13-2025, the Regional Health Care Director Specialist developed a spread sheet that includes the following

182b - Prescription Medication (continued)

information: Med Tech Name; Initial Certification, Last Observation, Next Due Observation, Annual Practicum, Next Annual Practicum. Upon successful completion of the Department-Approved Medication Administration course and requirements, the Regional Health Care Director Specialist/designee will add staff names to the spreadsheet and document subsequent due dates on the form. Any Medication Technician no longer employed at this community will have their names removed from the list. Beginning 8-16-2025, the Health Care Director will be responsible for reviewing the spread sheet monthly to coordinate in advance observations, and annual practicums with the Regional Health Care Director Specialist and Medication Technicians ensuring adherence to the due date.

Outcomes of the Medication Technician Compliance spread sheet will be discussed by the Health Care Director/designee at the Quality Assurance Meeting scheduled for 10-16-2025. Revisions, if necessary to the procedure will be discussed at that time. The Health Care Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

183b - Meds and Syringes Locked

24. 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 08/12/25, at approximately 10:30 AM, several medications including Allopurinol 100 MG Tablet and Hydroxyzine HCl Tablet 10 MG for resident #7 and Butal/Acetamn/CF 50-325 MG and Lorazepam 0.5 MG Tablet for resident #8 were unlocked, unattended, and accessible in the Healthcare Director's Office on the 5th floor.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure the prescription medications; OTC medications CAM and syringes are kept in an area or container that is locked. On 8/12/2025, several medication including Allopurinol 100 MG Tablet and Hydroxyzine HCL Tablet 10 MG for resident #7 and Butal/Acetamn/CF 50-325 MG and Lorazepam 0.5 MG tablet for resident 8 were unlocked, unattended and accessible in the Health Care Director's Office.

On 8-12-2025, all medications were immediately removed from the Health Care Director's Office by the Health Care Director and subsequently secured in a locked storage area.

On 8-18-2025, The Health Care Director was inserviced by the Residence Director concerning medication storage. Inservicing referenced regulation 2600.183b and included the Medication Storage policy as outlined in the community pharmacy provider's policy and procedure manual.

183b - Meds and Syringes Locked (continued)

Beginning 8-19-2025 and until further notice, to ensure compliance with medication storage policies, the Residence Director/designee will conduct an audit 5x/week (once daily) at a random time throughout the day of the Health Care Director's Office. During each audit, the Residence Director/designee will verify that the Health Care Director's office door is locked when the office is unattended. Any discrepancies such as an unlocked door or improperly stored medications will be immediately addressed with the Health Care Director. Any reoccurring issues identified will result in additional training and auditing follow-up,

Outcomes of this audit and ongoing auditing frequency will be discussed by the Residence Director at the Quality Assurance Meeting scheduled for 10-16-2025. The Health Care Director will have the responsibility for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

Implemented (- 10/21/2025)

183e - Storing Medications

25. 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 08/13/25, a puncture was observed in the #1 slot of a blister card containing resident #5's Trazadone Tab 100 MG. The tablet was still in the package.

Repeat Violation: 01/30/25, and 10/28/24, et. al.

Plan of Correction ***Accept (- 09/30/2025)***

Revelle Senior Living will ensure that all Prescription Medications, OTC medications and CAM, are stored in an organized manner under proper conditions of sanitation, temperature, moisture, light and in accordance with manufacturer's directions. On 8-13-2025, a puncture was observed in the #1 slot of a blister card containing resident 5's Trazadone. The tablet was still in the package.
On 8-13-2025, the Trazadone was removed from the packaging and subsequently destroyed. The disposal process was documented and verified by the signatures of 2 staff members.
.
Beginning 8-14-2025, the Health Care Director and designated staff conducted a thorough review of all Medication Carts to confirm that medication packaging was intact and that medications were stored in compliance with the

183e - Storing Medications (continued)

manufacturer's guidelines. Any medications found with compromised or damaged packing would be discarded. Auditing was completed on 8-20-2025. This review identified no other issues with the packaging or storage of medications.

Starting August 28, 2025, Inservice training was provided by the Health Care Director to all licensed nursing staff and medication technicians. The In-service topics included: Proper medication storage and disposal of medications with emphasis placed on the immediate removal of medications that are discontinued, expired, contaminated, deteriorated or unlabeled and those that are in containers that are cracked, spoiled or improperly sealed and glucometer readings documentation. Inservicing on these topics will be continued until all licensed nursing staff and medication technicians are trained. On 8-19-2025 the Health Care Director implemented a Cart Audit Form. This audit includes checking medication expiration dates, confirming the use of open date stickers, confirming proper medication storage and packaging, discontinuing PRN medications not administered in 3 months, conducting Med to MAR audits and glucometer readings and documentation. Any issues identified by licensed nursing staff or medication technicians are documented on the Cart Audit Form and the Health Care Director or Assistant Health Care Director notified. All cart audit forms are reviewed and signed off by the Health Care Director or Assistant Health Care Director. Until further notice, the audit will involve reviewing 5 resident medication regimes per shift each day and will be conducted by licensed nursing staff or the medication technicians. Any patterns of noncompliance identified by the cart audit will be discussed by the Health Care Director or Assistant Health Care Director directly with the staff person involved. Continued noncompliance will result in disciplinary action, up to and including removal from the Medication Administration Program or termination. Additional new residents will be added to the Cart Audit Form upon admission.

Outcomes of the review of the Cart Audit Form will be discussed by the Health Care Director or the Assistant Health Care Director. at the Quality Assurance Meeting on 10-16-2025. The Health Care Director will have the responsibility of maintaining ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

185a - Implement Storage Procedures

26. Requirements

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

Description of Violation

Resident #4 is prescribed Metronidazole Cream 0.75 grams - Apply topically a small amount to face twice daily as needed. On 08/13/25, this medication was not available in the home.

Repeat Violation: 01/30/25

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living has developed and implemented procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. Resident #4 was prescribed

185a - Implement Storage Procedures (continued)

Metronidazole Cream 0.75 grams - Apply topically a small amount to face twice daily as needed. On 8-13-2025, this medication was not available. Resident #4 physician was contacted on 9-2-2025 and the medication discontinued due to non-use by the Nurse Practitioner.

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Beginning 8-14-2025, the Health Care Director and designated staff conducted a thorough review of all Medication Carts / MAR to confirm all medications ordered were available on the med cart. Auditing was completed on 8-20-25. Any issues identified during this audit were corrected by the Health Care Director/designee.

Starting August 28, 2025, Inservice training was provided by the Health Care Director to all licensed nursing staff and medication technicians. The In-service topics included: Proper medication storage and disposal of medications with emphasis placed on the immediate removal of medications that are discontinued, expired, contaminated, deteriorated or unlabeled and those that are in containers that are cracked, spoiled or improperly sealed. In addition, the Health Care Director discussed the importance of recording all glucometer readings on the MAR reordering medications. Inservicing on these topics will be continued until all licensed nursing staff and medication technicians are trained. On 8-19-2025 the Health Care Director implemented a Cart Audit Form. This audit includes checking medication expiration dates, confirming the use of open date stickers, confirming proper medication storage and packaging, discontinuing PRN medications not administered in 3 months, conducting a Med to MAR audit for availability of medications and documentation of glucometer readings on the MAR. Any issues identified by licensed nursing staff or medication technicians are documented on the Cart Audit Form and the Health Care Director or Assistant Health Care Director notified. All cart audit forms are reviewed and signed off by the Health Care Director or Assistant Health Care Director. Until further notice, the audit will involve reviewing 5 resident medication regimes per shift each day and will be conducted by licensed nursing staff or medication technicians. Any patterns of noncompliance identified by the cart audit will be discussed by the Health Care Director or Assistant Health Care Director directly with the staff person involved. Continued noncompliance will result in disciplinary action, up to and including removal from the Medication Administration Program or termination. Additional new residents will be added to the Cart Audit Form upon admission. For additional oversight and for auditing purposes on 9-22-2025, Revelle Senior Living's pharmacy provider will be on site in the community to conduct a MAR to Cart audit. Outcomes or opportunities for improvement will be discussed with Health Care Director for implementation.

Outcomes of the review of the Cart Audit Form will be discussed by the Health Care Director or the Assistant Health Care Director. at the Quality Assurance Meeting on 10-16-2025. The Health Care Director will have the responsibility of maintaining ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

27. 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 prescribed blood glucose checks 3 times a day before meals. A review of the resident's glucometer shows that the readings on 08/12/25 at 8:31 AM (blood glucose reading of 88), 11:39 AM (121) and at 3:25 PM (133) were

185a - Implement Storage Procedures (continued)

not documented on the residents August 2025 Medication Administration Record (MAR).

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that all Prescription Medications, OTC medications and CAM, are stored in an organized manner under proper conditions of sanitation, temperature, moisture, light and in accordance with manufacturer's directions. Resident #5 is prescribed glucose checks 3 times a day before meals. The resident's glucometer shows that the readings for 8/12/2025 were not documented on the resident's August 2025 Medication Administration Record. The individual responsible for performing and documenting the glucometer checks was re-educated by the Assistant Health Care Director on 8-13-2025 and the Assistant Health Care Director reviewed the procedure for documenting the glucometer results on the MAR.

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Beginning 8-14-2025, the Health Care Director and designated staff reviewed the glucometer readings for individual residents who have an order for blood glucose testing and resulting MAR documentation. Any discrepancies noted during this review will be discussed with the individual responsible for performing and documenting the glucometer results on the MAR. Review completed 8-20-2025.

Starting August 28, 2025, Inservice training was provided by the Health Care Director to all licensed nursing staff and medication technicians. The In-service topics included: Proper medication storage and disposal of medications with emphasis placed on the immediate removal of medications that are discontinued, expired, contaminated, deteriorated or unlabeled and those that are in containers that are cracked, spoiled or improperly sealed, glucometer readings/documentation on the MAR and reordering medications. Inservicing on these topics will be continued until all licensed nursing staff and medication technicians are trained. On 8-19-2025 the Health Care Director implemented a Cart Audit Form. This audit includes checking medication expiration dates, confirming the use of open date stickers, confirming proper medication storage and packaging, discontinuing PRN medications not administered in 3 months, conducting a Med to MAR audit and comparing Glucometer readings to the MAR. Any issues identified by licensed nursing staff or medication technicians are documented on the Cart Audit Form and the Health Care Director or Assistant Health Care Director notified. All cart audit forms are reviewed and signed off by the Health Care Director or Assistant Health Care Director. Until further notice, the audit will involve reviewing 5 resident medication regimes per shift each day and will be conducted by licensed nursing staff or medication technicians. Any patterns of noncompliance identified by the cart audit will be discussed by the Health Care Director or Assistant Health Care Director directly with the staff person involved. Continued noncompliance will result in disciplinary action, up to and including removal from the Medication Administration Program or termination. Additional new residents will be added to the Cart Audit Form upon admission.

Outcomes of the review of the Cart Audit Form will be discussed by the Health Care Director or the Assistant Health Care Director. at the Quality Assurance Meeting on 10-16-2025. The Health Care Director will have the responsibility of maintaining ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

185a - Implement Storage Procedures *(continued)*

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

187d - Follow Prescriber's Orders

28. Requirements

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

Description of Violation

Resident #3 is prescribed Hydrazaline 25 MG Tablet, Aspirin Chw 81 MG, Docusate Sod Cap 100 MG, Fenofibrate Cap 200 MG. However, these medication were not administered to resident #3 on 8/10/25 and 8/11/25 because the medications were not available in the home.

Resident #9 is prescribed Lacosamide Tab 100 MG (Vimpat) - take 1 tab orally twice daily at 8:00 am and 7:00 pm. However, resident #9 was administered Lacosamide Tab 100 MG on 08/02/25 at 9:41 am, 8/03/25 at 9:43 am, 8/07/25 at 9:14 am, 08/09/25 at 9:29 am, 08/10/25 at 10:42 am, 8/11/25 at 9:38 am and 8/13/25 at 9:21 am.

Repeat Violation: 01/30/25

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will follow the directions of the prescriber. Resident #3 was prescribed Hydrazaline 25 MG Tablet, Aspirin Chew 81 MG, Docusate Sod Cap 100 MG, Fenofibrate Cap 200 MG, however, these medications were not administered as the medications were not available in the community. The Health Care Director reviewed the Physicians Orders and the pharmacy was contacted on 8-12-2025 by the Health Care Director to deliver those medications. As verified by the Health Care Director, the medications were received on the evening of 8-12-2025 and placed in the cart on that evening. Resident #9 Is prescribed Lacosamide Tab 100MG - take 1 tab orally twice daily at 8am and 7pm. However resident #9 was administered Lacosamide Tab 100 MG on 8/2/25 at 9:41am, 8/3/25 at 9:43am, 8/7/25 at 9:14am, 8/9/25 at 9:29am, 8/10/25 at 10:42am, 8/11/25 at 9:38am and 8/13/25 at 9:21am. Upon review of the MAR the Health Care Director verified that those medications were not administered as per time on the physician order. Medication Technicians/Licensed Nursing personnel involved in administration were provided with an Inservice relating to the importance of administering medications at the documented times, as per physician's order.

Beginning 8-14-2025, the Health Care Director and designated staff conducted a thorough review of all Medication Carts / MAR to confirm all medications ordered were available on the med cart. Auditing was completed on 8-20-2025. Any discrepancies identified were corrected by the Health Care Coordinator/designee.

Starting August 28, 2025, Inservice training was provided by the Health Care Director to all licensed nursing staff and medication technicians. The In-service topics included: Proper medication storage and disposal of medications with emphasis placed on the immediate removal of medications that are discontinued, expired, contaminated, deteriorated or unlabeled and those that are in containers that are cracked, spoiled or improperly sealed. The importance of following physician orders was also discussed in relation to the administration times of medications.

187d - Follow Prescriber's Orders (continued)

In addition, the Health Care Director discussed the importance of recording all glucometer readings on the MAR. Inservicing on these topics will be continued until all licensed nursing staff and medication technicians are trained. On 8-19-2025 the Health Care Director implemented a Cart Audit Form. This audit includes checking medication expiration dates, confirming the use of open date stickers, confirming proper medication storage and packaging, discontinuing PRN medications not administered in 3 months, conducting a Med to MAR audit and documenting glucometer readings on the MAR. Any issues identified by licensed nursing staff or medication technicians are documented on the Cart Audit Form and the Health Care Director or Assistant Health Care Director notified. All cart audit forms are reviewed and signed off by the Health Care Director or Assistant Health Care Director. Until further notice, the audit will involve reviewing 5 resident medication regimes per shift each day and will be conducted by licensed nursing staff or medication technicians. Any patterns of noncompliance identified by the cart audit will be discussed by the Health Care Director or Assistant Health Care Director directly with the staff person involved. Continued noncompliance will result in disciplinary action, up to and including removal from the Medication Administration Program or termination. Additional new residents will be added to the Cart Audit Form upon admission. For additional oversight and for auditing purposes on 9-22-2025, Revelle Senior Living's pharmacy provider will be on site in the community to conduct a MAR to Cart audit. Outcomes or opportunities for improvement will be discussed with Health Care Director for implementation.

Outcomes of the review of the Cart Audit Form will be discussed by the Health Care Director or the Assistant Health Care Director. at the Quality Assurance Meeting on 10-16-2025. The Health Care Director will have the responsibility of maintaining ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

190a - Completion Medication Course

29. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person D, who has not successfully completed the annual practicum for the Department-approved medications administration course, administered medications to residents on 08/27/25 at 12:00 PM.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that a Medication Technician has successfully completed a Department-approved medication administrations course that includes the passing of the Department's performance-based competency test within the past 2 years in order to administer oral, topical, eye, nose and ear drop prescriptions medications and epinephrine injections for insect bites and other allergies. Staff person D was immediately removed from the

190a - Completion Medication Course (continued)

Medication Technician role by the Health Care Coordinator on 8-13-2025, pending the completion of the required documentation. Staff person D had [redacted] annual practicum completed on 8-14-2025 and subsequently returned to the Medication Technician role on 8-15-2025.

To ensure that medication is administered safely and in accordance with best practice by trained professionals, on 8-13-2025 and 8-14-2025, the Regional Health Care Director Specialist conducted a thorough review of each current Medication Technician's qualifications to verify that each staff person has the proper credentialing and are current with observations and practicums. As of 8-15-2025, all Medication Technicians are current with their Medication Technician observations and annual practicums.

On 8-13-2024, Regional Health Care Director Specialist, developed a spread sheet that includes the following information: Med Tech Name; Initial Certification, Last Observation, Next Due Observation, Annual Practicum, Next Annual Practicum, Diabetic Certification Upon successful completion of the Department-approved Medication Administration course, the Regional Health Care Director Specialist/Designee will add staff names to the spreadsheet and document subsequent due dates on the form . Any Medication Technician no longer employed at this community will have their names removed from the list. Beginning 9-1-2025, The Health Care Director will be responsible for reviewing the spread sheet monthly to coordinate in advance observations, and annual practicums with the Medication Technicians ensuring adherence to the due date. All current Medication Technicians now have the required documentation in order to administer medications. On 8-15-2025, the Health Care Director was inserviced by the Residence Director relative to regulation 2600.190a.

Outcomes of the Medication Technician Compliance spread sheet will be discussed by the Health Care Director/Designee at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary to the procedure will be discussed at that time. The Health Care Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

190c - Record of Training

30. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person E does not include the date, documentation of successful completion of the initial training in [redacted] The home does not have the annual practicums for staff person E

190c - Record of Training (continued)

since [redacted] but staff person E's record does contain a "Certificate of Completion" of the Modified Medication Administration Training Course dated March 4, 2025. This training stopped being acceptable after 07/31/22 and required completion of the standard course by 06/30/23.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that a Medication Technician has successfully completed a Department-approved medications administrations course that includes the passing of the Department's performance-based competency test within the past 2 years in order to administer oral, topical, eye, nose and ear drop prescriptions medications and epinephrine injections for insect bites and other allergies. Upon identification, staff person E was immediately removed from their Medication Technician position on 8-13-2025 by the Health Care Director pending completion of the department approved medication administration course and passing of the performance-based competency test. Staff person E completed the Medication Administration Standard Student Course and was observed on 8-15-2025. Staff Person E returned to the Medication Technician role on 8-15-2025. Staff person E next observation is due February 2026, and the next annual practicum is due 8/15/2026.

To ensure that medication is administered safely and in accordance with best practice by trained professionals, on 8-13-2025 and 8-14-2025, the Regional Health Care Director Specialist conducted a thorough review of each current Medication Technician's qualifications to verify that each staff person has the proper credentialing and are current with observations and practicums. All Medication Technicians are current with their Medication Technician observations and annual practicums. The Health Care Director was inserviced by the Residence Director on 8-15-2025 pertaining to regulation 2600.190c.

On 8-13-2025, the Regional Health Care Director Specialist developed a spread sheet that includes the following information: Med Tech Name; Initial Certification, Last Observation, Next Due Observation, Annual Practicum, Next Annual Practicum. Upon successful completion of the Department-Approved Medication Administration course and requirements, the Regional Health Care Director Specialist/designee will add staff names to the spreadsheet and document subsequent due dates on the form. Any Medication Technician no longer employed at this community will have their names removed from the list. Beginning 9-1-2025, the Health Care Director will be responsible for reviewing the spread sheet monthly to coordinate in advance observations, and annual practicums with the Regional Health Care Director Specialist and Medication Technicians ensuring adherence to the due date.

Outcomes of the Medication Technician Compliance spread sheet will be discussed by the Health Care Director/designee at the Quality Assurance Meeting scheduled for 10-16-2025. Revisions, if necessary to the procedure will be discussed at that time. The Health Care Director will be responsible for ongoing compliance.

190c - Record of Training (continued)

Licensee's Proposed Overall Completion Date: *10/20/2025*

Implemented (- 10/21/2025)

224a - Preadmission Screen Form

31. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #10 was admitted to the home on [redacted] however, the resident's preadmission screening form was completed on [redacted]

Resident #11 was admitted to the home on [redacted] however, the resident's preadmission screening form was completed on [redacted]

Plan of Correction ***Accept (- 09/30/2025)***

Revelle Senior Living will ensure that a determination is made within 30 days prior to admission and documented on the Department's Preadmission screening form that the needs of the resident can be met by the services provided in this community. Resident 10 was admitted on [redacted]; the pre-admission screening wasn't completed until [redacted] Resident 11 was admitted on [redacted] and the preadmission screening was not completed until [redacted]
Note: Revelle Senior Living was transitioned to new ownership on February 6, 2025.

The Assistant Health Care Director conducted an audit of all current resident files on 8-15-2025 recording the move-in date and the Preadmission Screening date onto the Chart audit form. Once completed, the Chart Audit Form was reviewed by both the Assistant Health Care Director and the Health Care Director, Any Preadmission screening forms found to be out of compliance with regulatory timeframes will have a document attached to the non-compliant Preadmission Screening Form in the resident's chart, indicating that the noncompliance was identified during the audit.

As of 8-14-2025, prior to move in, Revelle Senior Living, requires each resident's Preadmission Screening be completed before a move in date is provided. After receiving the completed Preadmission screening, the Health Care Director or Assistant Heath Care Director will review the preadmission to verify all required information is provided. and confirm that care needs can be provided by the community. Following the review, the Preadmission Screening Form completion date will be documented on the Chart Audit Form, and the potential resident will be provided with a move in date. Beginning 8-18-2025, the Health Care Director/designee will check the Chart Audit Form against the Preadmission Screening document for all new resident move-ins weekly to insure and verify that Preadmission screening dates are within the regulatory time frame. On 8-18-2025, the Residence Director provided the Assistant Health Care Director and the Health Care Director with an Inservice training regarding the Preadmission Screening

224a - Preadmission Screen Form (continued)

process and regulation 2600.224a.

Outcomes of the Chart Audit Form will be discussed by the Health Care Director/Assistant Health Care Director at the Quality Assurance Meeting scheduled for 10-16-2025. Revisions, if necessary to the procedure will be discussed at that time. The Health Care Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

Implemented (- 10/21/2025)

225a - Assessment 15 Days

32. 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 was admitted on ; however, the resident's assessment was not completed until

Resident #10 was admitted on ; however, the resident's assessment was not completed until

Plan of Correction ***Accept (- 09/30/2025)***

Revelle Senior Living will ensure that a resident will have an initial written assessment that is documented on the Department's assessment form within 15 days of admission. Resident #3 was admitted on however, the resident's assessment was not completed until Resident #10 was admitted on however, the resident's assessment was not completed until Note: Revelle Senior Living transitioned to a new owner on February 6, 2025.

The Assistant Health Care Director conducted an audit of all current resident files on 8-15-2025, recording the move-in date and the initial assessment date onto the Chart Audit form. Once completed, the Chart Audit form was reviewed by both the Assistant Health Care Director and the Health Care Director. Initial assessments found to be out of compliance with regulatory timeframes will have a document attached to the non-compliant initial assessment in the resident's chart, indicating that the noncompliance was identified during the audit.

Upon a resident's admission, the Health Care Director or Assistant Health Care Director will add the new Residents name to the Chart Audit Form. Following addition of the new resident, the resident assessment will be completed within 15 days of admission. Once the assessment is completed, the date will be included on the Chart Audit Form. Once the assessment is completed The Chart Audit Form will be reviewed weekly by the Health Care Director or Assistant Health Care Director in order to verify that all initial assessments are completed within the regulatory time frame. Issues identified during the review will be corrected immediately. On 8-18-25, the Residence Director reviewed the Initial Assessment procedure with the Assistant Health Care Director and the Health Care Director.

225a - Assessment 15 Days (continued)

Regulation 225a was also discussed and the process for follow-up and timely completion of the Initial Assessment was reinforced.

Outcomes of the Chart Audit Form regarding the Initial Assessment will be discussed by the Health Care Director or Assistant Health Care Director at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary to the procedure will be discussed at that time. The Health Care Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

225c - Additional Assessment

33. 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 #6's current assessment was completed on [redacted] However, the resident's previous assessment was completed on [redacted]

Repeat Violation: 03/31/25, and 01/30/25

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that a resident will have an additional assessment as follows: Annually, If the condition of the resident significantly changes prior to an annual assessment and at the request of the Department upon cause to believe that an update is required. Resident 6 had an annual assessment dated [redacted] During a chart audit, the overdue assessment was identified and an annual assessment was completed on [redacted] an placed in the resident's chart. Note: Legend Senior Living transitioned to a new owner on February 6, 2025.

The Assistant Health Care Director conducted an audit of all current resident files on 8-15-2025, recording the move-in date and the date of annual assessment (or significant change assessment) onto the Chart Audit form. Once completed, the Chart Audit Form was reviewed by both the Assistant Health Care Director and the Health Care Director. Annual Assessments (or significant change assessments) identified to be out of compliance with regulatory timeframes will have a document attached to the non-compliant assessment in the resident's chart, indicating that the noncompliance was identified during the audit.

The Chart Audit Form will be reviewed weekly by the Health Care Director or Assistant Health Care Director in

225c - Additional Assessment (continued)

order to verify that all assessments are completed within the regulatory time frame. Any issues identified with the completion of an annual assessment will be corrected immediately by the Health Care Director of the Assistant Health Care Director. On 8-18-2025, the Residence Director reviewed the annual assessment completion process and discussed regulation 2600.225c with the Assistant Health Care Director and the Health Care Director.

Outcomes of the Chart Audit form and annual assessment completion will be discussed by the Health Care Director or Assistant Health Care Director at the Quality Assurance Meeting scheduled for 10-16-2025. Revisions, if necessary to the procedure will be discussed at that time. The Health Care Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

234b - Support Plan Needs Elements

34. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated [redacted] for resident #4 does not address the change in the resident's diet order to pureed foods dated [redacted].

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that each resident's support plan identifies the resident's physical, medical, social, cognitive and safety needs. The Support Plan dated [redacted] for resident 4 does not address the change in the resident's diet order to pureed foods dated [redacted] Resident 4's support plan was updated by the Health Care Director on 8-13-2025 and now reflects the change in the resident's diet order to pureed.

Beginning 8-26-25, the Health Care Director/designee conducted a comprehensive review of each resident's diet order to ensure that the most current dietary order was reflected on each resident's support plan. This audit verified that all resident support plans now include the correct and up to date diet orders, and no discrepancies were identified.

Beginning 9-1-25, and utilizing a variety of information sources including but not limited to communication logs, physician orders, AM team meeting discussions, incident reports and information from the resident themselves, the Health Care Director and Assistant Health Care Director will ensure that each resident's physical, mental, social, cognitive and safety needs are met and their current status is accurately reflected on the support plan. 5 resident support plans will be reviewed each week by the Health Care Director/Assistant Health Care Director/designee

234b - Support Plan Needs Elements (continued)

updating them to include any current information and discontinuing any outdated or inaccurate information. Once the process of reviewing 5 resident support plans a week is complete, the procedure of updating a resident's support plan to reflect a resident's current status will be ongoing. On 8-18-2025, the Residence Director inserviced the Health Care Coordinator and the Assistant Health Care Coordinator on regulation 2600.234b and reviewed the process of updating support plans.

Outcomes of the Support Plan review will be discussed by the Health Care Director/designee at the Quality Assurance Meeting scheduled for 10-16-2025. Revisions if necessary to the procedure will be made at that time. The Health Care Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

234d - Support Plan Revision

35. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

A support plan for resident #4 was completed on [redacted]; however, the previous support plan was completed on [redacted]

Repeat Violation: 5/1/2025, et al

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that each resident's support plan is revised at least annually and as the resident's condition changes.
The support plan for resident 4 was completed on [redacted] It was noted during a chart audit that the prior review had occurred on [redacted] Upon identifying this overdue update, the support plan was brought current on [redacted] Note: Legend Senior Living transitioned to a new owner on February 6, 2025.

Beginning 8-15-2025, the Assistant Health Care Director conducted a comprehensive audit of all current resident files, documenting each resident's move in date and the date of their most recent support plan on the Chart Audit form. Once completed, the Chart Audit form was reviewed by both the Assistant Health Care Director and the Health Care Director. Any Support Plans identified to be out of compliance with regulatory timeframes will have a document attached to the non-compliant support plan in the resident's chart, indicating that the noncompliance was identified during the audit.

The Chart Audit form will be reviewed weekly by the Health Care Director or Assistant Health Care Director in order to verify that all support plans are completed and within the regulatory time frame. Any issues identified with the completion of a support plan will be corrected immediately by the Health Care Director or the Assistant Health

234d - Support Plan Revision (continued)

Care Director. On 8-18-2025, the Residence Director reviewed the support plan completion process and discussed regulation 2600.234d with the Assistant Health Care Director and the Health Care Director. Timely completion of the support plan that is reflective of the resident's current status was emphasized.

Outcomes of the Chart Audit form and annual support plan completion will be discussed by the Health Care Director or Assistant Health Care Director at the Quality Assurance Meeting scheduled for 10-16-2025. Revisions, if necessary to the procedure will be discussed at that time. The Health Care Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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

236 - Staff Training

36. 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 C, who works in the Secure Dementia Care Unit (SDCU) had only 4.42 hours of training in dementia care during the 2024 training year.

Plan of Correction ***Accept ([redacted] - 09/30/2025)***

Revelle Senior Living will ensure that every direct care staff person working in our Secured Dementia Care Unit receives six hours of annual training specifically focused on dementia care and services. This training is in addition to the 12 hours of annual training required under regulation 2600.65. Staff person C, had only 4.42 hours of training in dementia care during the 2024 training year.

As of February 6, 2025 this community transitioned to new ownership. The Business Office Director confirmed that

236 - Staff Training (continued)

2024 Dementia training records for staff person C are not available in the community. In addition, the Business Office Director confirmed that 2024 Dementia Training records for direct care staff could not be located in the community.

The community's dementia care training program is detailed in Relias, our educational training platform. For the 2025 training calendar, which is effective from February 2025 through December 2025, all direct care staff are assigned and required to complete six hours of annual dementia care training. Direct care staff receive participation reminders via email alerts directly from Relias. To ensure compliance, the Business Office/designee monitors monthly participation in the dementia care training sessions. Training completion records for the direct care staff are printed from the Relias system and filed in the Memory Care Training binder. Any staff member who does not meet the mandatory annual training requirement will be subject to disciplinary action, up to and including termination. The Residence Director will review regulation 2600.236 with the Business Office Director by 9-22-2025 and discuss the procedures for monitoring and review of employee participation and attendance.

Outcomes of the monthly review of the Dementia Care Training Log will be discussed by the Business Office Director/designee at the Quality Assurance Meeting scheduled for 10-16-2025. Any revisions, if necessary to the procedure will be discussed at that time. The Residence Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/20/2025*

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