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

December 19, 2025

SUNNY CREST HOME INC

RE: SUNNY CREST HOME
2587 VALLEY VIEW ROAD
MORGANTOWN, PA, 19543
LICENSE/COC#: 32192

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/18/2025, 08/19/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SUNNY CREST HOME* **License #**: *32192* **License Expiration**: *11/20/2025*

Address: *2587 VALLEY VIEW ROAD, MORGANTOWN, PA 19543*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *SUNNY CREST HOME INC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/05/2007* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *59* **Waking Staff**: *44*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/19/2025*

Inspection Dates and Department Representative

08/18/2025 - On-Site:
08/19/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *71* **Residents Served**: *54*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *22* **Are 60 Years of Age or Older**: *35*
Diagnosed with Mental Illness: *24* **Diagnosed with Intellectual Disability**: *54*
Have Mobility Need: *5* **Have Physical Disability**: *3*

Inspections / Reviews

08/18/2025 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/21/2025*

09/24/2025 - POC Submission

Submitted By: **Date Submitted**: *10/23/2025*

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

Inspections / Reviews *(continued)*

09/30/2025 POC Submission

Submitted By: [redacted] **Date Submitted**: *10/23/2025*

Reviewer: [redacted] **Follow Up Type**: *Document Submission* **Follow Up Date**: *10/24/2025*

12/19/2025 Document Submission

Submitted By: [redacted] **Date Submitted**: *10/23/2025*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On [redacted], the most recent renewal violation report, dated [redacted], the home's current license and the chapter 2600 regulations were posted behind a locked glass bulletin board and inaccessible for public.

Plan of Correction ***Directed [redacted] 09/30/2025)***

Administrator- as reviewed The personal care home regulation 3c. posting the current license, as of 8/18/2025 the bulletin board will remain unlock at all time, the staff supervisor will train the staff on 10/15/2025 at the staff meeting on the personal care home regulation 3.c. the license being accessible to the public at all times and will be monitored by the staff supervisor / or charge staff weekly

[Directed]

- *In addition to the steps above, beginning no later than 10/20/25, the bulletin board will be audited weekly by the staff supervisor, charge staff or designee to ensure compliance. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: *10/20/2025*

Implemented [redacted] - 12/19/2025)

18 - Compliance With Laws

2. 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

According to the Care Facility Carbon Monoxide Alarm Standards Act, carbon monoxide alarms must be installed in close proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance. On [redacted], there was no carbon monoxide detection device around or in the vicinity of the commercial stove located in the downstairs kitchen.

According to the Care Facility Carbon Monoxide Alarm Standards Act, if the Carbon Monoxide (CO) alarm operates by a battery, the battery must be labelled with the date of installation and be replaced at least once annually. On [redacted], the CO alarm located in the laundry room and the CO alarm located in the boiler room did not have a label indicating the date the batteries had been installed.

The Influenza Awareness Act, effective July 2016, states that "Each facility shall ensure that the required influenza information is posted in a public place in the facility year-round." However, on [redacted] the home did not have a copy of the influenza awareness poster posted in a public place.

The home did not produce a valid Certificate of Boiler or Pressure Vessel Operation issued by the PA Department of Labor and Industry as required by 34 Pa.Code Chapter 3, the Boilers and Unfired Pressure Vessels regulations.

18 - Compliance With Laws (continued)

Plan of Correction ***Directed ████ - 09/30/2025)***

see attached:
The influenza awareness act was posted 8/18/2025 by a staff member. maintenance staff obtain a current boiler certificate 1/14/2025 . maintenance staff label the CO alarm batteries 8/19/2025 near the boiler room ,and laundry room. and install a CO 9/23/2025 by the stove in the downstair kitchen. administrator will do a walk through starting 9/23/2025 daily

[Directed]

- *In addition to the steps above, the administrator or designee will educate the maintenance staff and any other staff responsible for compliance on the Influenza Awareness Act, Care Facility Carbon Monoxide Alarm Standards Act and 34 Pa.Code Chapter 3, the Boilers and Unfired Pressure Vessels regulations. This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented ████ - 12/19/2025)

19 - Review Waiver

3. Requirements

2600.
19.e. The home shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department’s written decision shall be posted in a conspicuous and public place within the home.

Description of Violation

On ████ the home received a waiver for administration of ████ medications. However, this waiver was not posted in a conspicuous and public place.

Plan of Correction ***Directed ████ - 09/30/2025)***

The personal care home regulation 19.e. the waiver was posted in the bulletin board by LPN staff member 8/19/2025 and the resident and the designated person can see a copy of it as of 9/24/2025 The LPN staff member will be monitor by the administrator on a weekly basis to ensure any and all waiver are posted in a conspicuous and public place in the home
see attached;

[Directed]

- *In addition to the steps above, the administrator or designee will educate the LPN staff member and any other staff responsible for compliance on regulation 19(e). This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*

19 - Review Waiver *(continued)*

Directed Completion Date: *10/20/2025*

Implemented (AC - 12/19/2025)

60a - Staff/Support Plan

4. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

From 10:00 PM on [redacted] through 6:00 AM on [redacted], there were no staff present in the home trained in Medication Administration. There were no scheduled medications at the home during this time; however, the following residents have these medications scheduled pro re nata (PRN):
Resident [redacted]: [redacted] as needed for [redacted]
Resident [redacted] [redacted] as needed for [redacted], [redacted] as needed for [redacted]
checks as needed for [redacted]
Resident [redacted] as needed for [redacted]
Resident [redacted] [redacted] as needed for [redacted]
Resident [redacted]: [redacted] as needed for [redacted] and [redacted] related to [redacted]
Resident [redacted] [redacted] as needed for [redacted]

Plan of Correction ***Directed [redacted] 09/30/2025)***

Personal care home 60.a. Staffing shall be provided to meet the needs of the residents as specified in the assessment and support plan. staff has completed the medication administration lesson 9/23/2025 and taken the test and pass 9/29/2025
med pass training will begin with the trainer to trainer and the LPN will monitor the med Aide during the med pass.10/6/2025

[Directed]

- *In addition to the steps above, the administrator or designee will educate the LPN staff and any other staff responsible for compliance on regulation 60(a). This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*
- *Beginning no later than 10/20/25, the administrator or designee will audit the work schedules prior to the work schedules being posted to ensure compliance. Documentation of these audits will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented [redacted] 12/19/2025)

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.

63a - First Aid/CPR Training *(continued)*

Description of Violation

From 10:00 PM on [redacted] to 6:00 AM on [redacted] 54 residents were present in the home. During this time 1 staff person was present in the home who was certified in First Aid and CPR.

From 10:00 PM on [redacted] to 6:00 AM on [redacted] 54 residents were present in the home. During this time there were no staff persons present in the home who were certified in First Aid and CPR.

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

Administrator reviewed the regulation and compliance guide for the personal care home 63.a. Staff training in CPR/First Aide was done on 8/18/2025 , the staff that attended the training class , is schedule for the 10pm-6am shift. Therefor there are two trained staff on the overnight shift. As of 9/24/2025 The administrator review all the dates of the employee's most recent CPR training to make sure that no other employee's CPR/First Aide training expires before they are able to receive the training course

[Directed]

- *Beginning no later than 10/20/25, the administrator or designee will complete quarterly audits of staff First Aid and CPR certifications to ensure compliance. Documentation of these audits will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented [redacted] - 12/19/2025)

82c - Locking Poisonous Materials

6. Requirements

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

Description of Violation

On [redacted] a bottle of [redacted] with warning label stating, "Caution: keep out of reach of children. In case of accidental ingestion, seek professional assistance or contact a Poison Control Center immediately" were unlocked, unattended and accessable on the counter of the sink in the A- Wing shower room. There was also an unlocked box was located in a drawer of the A-Wing shower room. Within this box, there were multiple accessible hygiene items including a bottle of powder stating, "Keep out of reach of children and, warning, do not use near face to avoid inhalation". Not all the residents of the home, including resident [redacted] and resident [redacted] have been assessed capable of recognizing and using poisons safely.

Repeated Violation - [redacted] et al

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

see attached
reviewing the personal care home regulation 82.c. poisonous material should be kept locked . the staff supervisor as of 9/24/2025 will ensure through training the staff do a walk through after the resident have use the rest room to ensure nothing has been left out. and is locked up. Staff supervisor /or charge staff will monitor daily, to ensure residents safety

82c Locking Poisonous Materials (continued)

[Directed]

- *In addition to the above steps, the administrator, staff supervisor or designee will secure the identified bottles no later than 10/6/25.*
- *The administrator or designee will educate staff on regulation on 82(c). This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*
- *Beginning no later than 10/20/25, the staff supervisor, charge staff or designee will complete daily walkthroughs of the home to ensure compliance. Documentation of these walkthroughs will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented [redacted] - 12/19/2025)

87 - Lighting

7. Requirements

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On [redacted] the exit door in the dining room hallway had no exterior light source.

Plan of Correction ***Directed [redacted] 09/30/2025)***

See attached;

Personal care home regulation 87. lighting outside the dining room exit door, was installed by the maintenance staff 8/18/2025 , administrator will meet with maintenance staff monthly starting 10/7/2025 maintenance staff and administrator will do a walk through audit

[Directed]

- *In addition to the steps above, the administrator or designee will educate maintenance staff on regulation on 87. This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented [redacted] - 12/19/2025)

89b - Hot Water Temperature

8. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On [redacted], at 3:17 PM, the hot water temperature at the sink in bathroom of resident room [redacted] measured 126.9 degrees Fahrenheit.

89b - Hot Water Temperature *(continued)*

Plan of Correction ***Directed - 09/30/2025)***

see attached;
8/19/2025 maintenance staff replaced the hot water valve , to prevent this issue in the future, the administrator will meet with the maintenance staff weekly to review regulation maintenance starting 9/24/2025, maintenance staff will do daily temperature starting 9/24/2025

[Directed]

- *In addition to the steps above, the administrator or designee will educate maintenance staff on regulation on 89(b). This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented - 12/19/2025)

91 - Telephone Numbers

9. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone located outside of the dining room, near the F hallway.

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

Personal care home regulation 91. emergency phone number to the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted by each phone with and outside line. The Housekeeping staff on 8/19/2025 posted the phone numbers for the 911 emergency on the phone and the wall for the residents to see. 10/15/2025 at the staff meeting , staff will be trained on the regulation, administrator will do a daily walk through starting 9/24/2025

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

Implemented (- 12/19/2025)

101o - Walls, Floors, Ceilings

10. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The linoleum floor of resident room # had scuff marks located at the entrance of the room.

The carpet in front of the personal refrigerator in resident room #F8 has a brown stain approximately 2 inches by 3 inches in size.

101o Walls, Floors, Ceilings *(continued)*

Plan of Correction ***Directed - 09/30/2025)***

personal care home regulation 101.o. The bedroom floors should be cleaned and in good repair. the housekeeping staff cleaned the carpet 8/21/2025, met with the housekeeping supervisor to discuss the cause and solution in keeping the carpet clean 8/25/2025. As of 9/24/2025 administrator will do a daily walk through to follow up using the observation

[Directed]

- *In addition to the steps above, the administrator or designee will educate housekeeping staff on regulation on 101(o). This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented - 12/19/2025)

132g - Fire Drills Days/Times

11. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home conducted a sleeping hour fire drill on at 5:30 AM. The previous sleeping hour drill was conducted on at 5:30 AM.

Plan of Correction ***Directed - 09/30/2025)***

The administrator and the Executive Director had a meeting 8/21/2025 to Creating a schedule to confirm the drills are done at different times during the overnight shift 10pm 6am. The maintenance staff will be given a schedule by 11/1/2025
maintenance staff person will conduct a drill schedule every 6 months

[Directed]

- *In addition to the steps above, the administrator or designee will educate maintenance staff on regulation on 132(g). This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*
- *Beginning no later than 10/20/25, the administrator or designee will complete quarterly audits of the home's fire drill records to ensure compliance. Documentation of these audits will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented 12/19/2025)

141a 1-10 Medical Evaluation Information

12. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident [redacted]'s initial medical evaluation, dated [redacted], did not include special health and dietary needs, the resident's ability to self-administer medications, and a mobility needs assessment.

Repeated Violation - [redacted] et al

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

the administrator on daily bases starting 8/20/2025 (doing one file a day) go thought the files to ensure that all the forms are provided and filled out correctly, with the LPN staff Paying special attention to diets, health, and mobility to self admin meds. the administrator has retrained the LPN staff member 8/20/2025 that is responsible. for completing the DME. they will be done according to the regulation 141.a.

[Directed]

- *In addition to the steps above, the administrator, LPN staff or designee will update resident #4's DME no later than 10/20/25*
- *The administrator, LPN staff or designee will complete an initial audit of all current DMEs by 10/20/25. Documentation of this audit will be kept and available to the Department for review.*
- *Beginning no later than 10/20/25, the administrator, LPN staff or designee will complete quarterly audits of current DMEs to ensure compliance. Documentation of these audits will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented [redacted] 12/19/2025)

141b1 - Annual Medical Evaluation

13. Requirements

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

Description of Violation

Resident [redacted] most recent annual medical evaluation, dated [redacted] did not include health status and a cognitive functioning assessment.

141b1 Annual Medical Evaluation (continued)

Resident ██ most recent annual medical evaluation was completed on ██. The resident's previous annual medical evaluation was completed on ██

Resident ██ most recent annual medical evaluation, dated ██, did not include special health and dietary needs.

Plan of Correction ***Directed (██ - 09/30/2025)***

See attached.
the DME for residents ██ will be reviewed 9/25/2025 and read back to the admin staff preparing it, by the Administrator to ensure accuracy. All the completed DME will be audited starting 10/1/2025 to ensure that all the information is addressed an documented. quarterly review will be done by the administrator starting 11/1/2025

[Directed]

- *In addition to the steps above, the administrator, LPN staff or designee will update resident #3 and #6's DMEs no later than 10/20/25.*
- *The administrator, LPN staff or designee will complete an initial audit of all current DMEs by 10/20/25. Documentation of this audit will be kept and available to the Department for review.*
- *The administrator or designee will educate the LPN staff and any other staff responsible for compliance on regulation 141(b)1. This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented ██ - 12/19/2025)

183b - Meds and Syringes Locked

14. Requirements

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

Description of Violation

On ██ at approximately 2:45 PM, ██ to resident #█ was unlocked, unattended, and accessible in resident ██s room.

On ██, at 3:00 PM, anti fungal powder, prescribed to resident ██, was unlocked, unattended, and accessible in the A Hall shower room.

Repeated Violation ██ et al

Plan of Correction ***Directed ██ - 09/30/2025)***

Med Aide staff will ensure starting 8/19/2025 residents ██ anti fungal cream, will be kept in a lock cabinet in the A. shower room and get it when the resident needs it, 8/19/2025 resident ██, anti itch cream is labeled and kept in a locked drawer in ██ room. administrator will educate the staff at the staff meeting 10/15/2025, on the regulation 183.b. OTC kept in a lock container that is in a residents room. Staff supervisor / charge Staff will monitor the

183b - Meds and Syringes Locked (continued)

residents rooms on a daily basis

[Directed]

- *In addition to the steps above, beginning no later than 10/20/25, the staff supervisor, charge staff and designee will complete monthly walkthroughs of resident rooms to ensure compliance. Documentation of these walkthroughs will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented (- 12/19/2025)

184b - Labeling OTC/CAM

15. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On , a bottle of belonging to resident was in resident s room and was not labeled with the resident's name

Plan of Correction ***Directed - 09/30/2025)***

Med aide staff remove and labeled OTC 8/19/2025. returned it to a locked draw in residents room. Staff will be train at the staff meeting 10/15/2025 on labeling and storing OTC in residents rooms, administrator/staff supervisor will do a walk through 9/25/2025 and checking the residents rooms, to ensure it doesn't happen again

[Directed]

- *Beginning no later than 10/20/25, the administrator, staff supervisor or designee will complete monthly audits of OTC medications to ensure all OTC medications are labeled with the residents' names. Documentation of these audits will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented - 12/19/2025)

185a - Implement Storage Procedures

16. Requirements

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

Description of Violation

On at 4:30 PM, a reading of was documented on the Medication Administration Record (MAR) for resident . However, this reading was not in the resident's glucometer.

On at 12:00 PM, a blood glucose reading of was documented on the MAR for resident . However, this reading was not in the resident's glucometer.

185a - Implement Storage Procedures (continued)

Repeated Violation - [redacted], et al

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

the Med Aide staff will make sure the glucometer reads the same as the MAR for the residents starting 8/25/2025 . The LPN staff will do a weekly checks of the glucometer and the MAR starting 9/1/2025. LPN staff will have a weekly meeting with Administrator to evaluate all meters 9/8/2025
as Administrator- inspect glucometer with the LPN to ensure accuracy starting 9/8/2025

[Directed]

- *The administrator or designee will educate the LPN and med aid staff on regulation 185(a). This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented [redacted] - 12/19/2025)

187d - Follow Prescriber's Orders

17. Requirements

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

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. When the resident moved in, the resident brought a bottle of [redacted] with [redacted] Staff administered the medication from this bottle to the resident from [redacted] at 7:00 AM. However, effective on [redacted] the physician's order stated the resident was prescribed [redacted] 99 mg tablet with orders to take one tablet by mouth daily.

Repeated Violation - [redacted] et al

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

personal care home regulation 187.d.
The home shall follow the directions of the prescriber. the physician orders on 7/31/2025 for resident [redacted] was prescribed [redacted] tablet , and the residents OTC bottle of [redacted] should have been destroyed 7/31/2025 by the LPN staff. Med Aide staff will be trained by LPN staff in the meeting on 9/3/2025 to follow physician orders according to personal care home regulation.

[Directed]

- *In addition to the above steps, the administrator, LPN staff or designee will order [redacted] tablets for resident [redacted] no later than 10/6/25.*

187d - Follow Prescriber's Orders (continued)

- *The administrator, LPN staff or designee will destroy resident [redacted] [redacted] tablet bottle no later than 10/6/25.*
- *Beginning no later than 10/20/25, the administrator, LPN staff or designee will complete monthly audits of resident medication administration records with the medication in the medication carts to ensure compliance. Documentation of these audits will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented [redacted] - 12/19/2025)

224a - Preadmission Screen Form

20. 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 [redacted] was admitted to the home on [redacted]. However, on [redacted] there was no preadmission screening form in the resident's record.

Resident [redacted] was admitted to the home on [redacted]. However, the resident's preadmission screening form, dated [redacted] did not include section I-D (the name of admitting personal care home), section I-F (screening information sources), section II-A (the name of resident), section II-B (date of birth), section II-C (primary language/means of communication), and section II-G (level of supervision needed).

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

See attached
.personal care home regulations 224.a. a determination shall be made within 30 days prior to admission and documented on the department preadmission screening form.
Administrator and admin staff will conduct the prescreening, assessment of residents 30 days prior. starting 9/25/2025, staff management meeting10/8/2025 administrator will educated the staff on the
regulations, all residents record will be evaluated by administrator for compliance starting 9/25/2025 and monthly audits will be done.

Licensee's Proposed Overall Completion Date: *10/08/2025*

Implemented [redacted] - 12/19/2025)

225a - Assessment 15 Days

21. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

225a - Assessment 15 Days *(continued)*

Description of Violation

Resident [redacted] was admitted to the home on [redacted] however, the resident's initial assessment was not completed until [redacted]

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

Repeated Violation - [redacted], et al

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

See attached. For Resident [redacted] and Resident [redacted]
personal care home regulation 225.a. 15 day assessment was completed by admin staff 7/31/2025 for resident [redacted] and resident [redacted] was completed 6/17/2025 . Administrator
will meet with Admin staff to review all assessment for residents on a quarterly basis to ensure the staff stays compliant with regulation 225.a. starting 10/1/2025

[Directed]

- *In addition to the steps above, the administrator or designee will educate the administrative staff on regulation 225(a). This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*
- *The administrator, administrative staff or designee will complete an initial audit of all current assessments to ensure compliance by 10/20/25. Documentation of this audit will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented ([redacted] 12/19/2025)

225c - Additional Assessment

22. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

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

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

225c - Additional Assessment *(continued)*

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

As Administrator starting 10/1/2025 all assessment plans will be completed annually , based on regulations 225.c. resident [redacted] assessment plan will be completed by 11/20/2025 and resident [redacted] by 4/21/2026 by Admin staff and will be read back to ensure its completed in a timely manner starting 10/1/2025 Administrator will do quarterly audits with staff to ensure they are completed on time starting 10/1/2025

[Directed]

- *In addition to the steps above, the administrator or designee will educate the administrative staff on regulation 225(c). This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*
- *The administrator, administrative staff or designee will complete an initial audit of all current assessments to ensure compliance by 10/20/25. Documentation of this audit will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented [redacted] 12/19/2025)

227a - Support Plan 30 Days

23. Requirements

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

Description of Violation

A support plan was not completed for resident [redacted] who was admitted to the home on [redacted]

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

PCH 227.a. shall have a written support plan developed and implement within 30 days. .The support plan will be completed and reviewed by the Admin staff and read back by the administrator. the regulation will be reviewed with Admin staff and Administrator in the management meeting10/8/25 all completed RASP will be audited by administrator to ensure its done on time

[Directed]

- *In addition to the steps above, the administrator or designee will complete an initial audit of all current support plans to ensure compliance by 10/20/25. Documentation of this audit will be kept and available to the Department for review.*
- *Beginning no later than 10/20/25, the administrator, administrative staff or designee will complete quarterly audits of current support plans to ensure compliance. Documentation of these audits will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented [redacted] 12/19/2025)

227d - Support Plan Medical/Dental

24. Requirements

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

Description of Violation

Resident utilizes a trapeze, a mechanical lift and bedside enabler bars. However, resident current support plan, dated does not include the specific need for these devices, the intended use and any risks associated with the use of these devices, the resident's ability to use these devices safely for the purpose it was intended and identification of the specific devices being used and whether a cover is required to meet FDA guidelines for the enabler bars.

Plan of Correction ***Directed - 09/30/2025)***

Resident has the trapeze listed on the plan ,1/24/2025 its to help with turning during the night, plan completed by admin staff . Administrator and admin staff will review plans and audits will be done quarterly starting 11/1/2025

[Directed]

- *In addition to the above steps, the administrator, administrative staff or designee will update resident # support plan to include the following information for all of resident mobility devices: the specific need for these devices, the intended use and any risks associated with the use of these devices, the resident's ability to use these devices safely for the purpose it was intended and identification of the specific devices being used and whether a cover is required to meet FDA guidelines for the enabler bars. This will be completed by 10/20/25.*
- *The administrator or designee will educate administrative staff on regulation 227(d). This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*
- *The administrator, administrative staff or designee will complete an initial audit of all current support plans to ensure compliance by 10/20/25. Documentation of this audit will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented - 12/19/2025)

252 - Record Content

25. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

Description of Violation

The following residents do not a photograph taken within the last 2 years in their record:

- *Resident photograph was taken .*
- *Resident photograph was taken*
- *Resident photograph was taken*
- *Resident photograph was taken*

252 Record Content (continued)

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

See attached. For Resident [redacted]
personal care home regulation 252. a photo of the resident shall not be more than 2 years old. a staff meeting with Administrator and staff on regulation 252. on 10/15/2025
Admin. staff took updated photo of the residents 9/17/2025, all resident records will be audited by administrator and admin staff starting 11/1/2025

[Directed]

- *In addition to the steps above, the administrator or designee will educate administrative staff on regulation 252(3). This education will be provided no later than 10/20/25. Documentation of this education will be kept and available to the Department for review.*
- *The administrator, administrative staff or designee will complete an initial audit of all resident records to ensure compliance by 10/20/25. Documentation of this audit will be kept and available to the Department for review.*
- *Beginning no later than 11/1/25, the administrator, administrative staff or designee will complete quarterly audits of resident records to ensure compliance. Documentation of these audits will be kept and available to the Department for review.*

Directed Completion Date: *10/20/2025*

Implemented [redacted] - 12/19/2025)