pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **VIDA SPRINGS SENIOR LIVING & PERSONAL CARE HOME, MONONGAHEL**
LEGAL ENTITY

To operate **VIDA SPRINGS SENIOR LIVING AND PERSONAL CARE HOME**
NAME OF FACILITY OR AGENCY

Located at **1378 FOURTH STREET, MONONGAHELA, PA 15063**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

PROVISIONAL

The total number of persons which may be cared for at one time may not exceed **28** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **November 13, 2025** until **May 13, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **455412**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: NOVEMBER 13, 2025

Vida Springs Senior Living and Personal Care Home, Monongahel

RE: Vida Springs Senior Living and Personal Care Home
1378 Fourth Street
Monongahela, Pennsylvania 15063
License/COC #: 455412

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on July 2, 2025, August 19, 2025, and August 27, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 455411) dated June 18, 2025 – December 18, 2025, and issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from NOVEMBER 13, 2025 to MAY 13, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

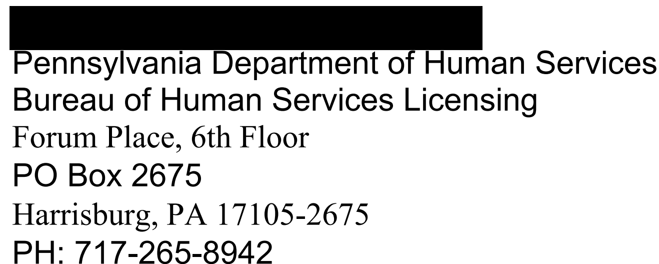
Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
184(a)	III	10	$3	$30	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:


Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

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

Facility Information

Name: *VIDA SPRINGS SENIOR LIVING AND PERSONAL CARE HOME* **License #**: *45541* **License Expiration**: *12/18/2025*

Address: *1378 FOURTH STREET, MONONGAHELA, PA 15063*

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

Administrator

Name: [redacted]

Legal Entity

Name: *VIDA SPRINGS SENIOR LIVING & PERSONAL CARE HOME, MONONGAHEL*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/13/2023* **Issued By**: *Carroll Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *17* **Waking Staff**: *13*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *07/02/2025*

Inspection Dates and Department Representative

07/02/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *28* **Residents Served**: *12*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *12*

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

Have Mobility Need: *5* **Have Physical Disability**: *0*

Inspections / Reviews

07/02/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/13/2025*

07/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/29/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/18/2025*

07/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/29/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/29/2025*

10/07/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/29/2025*

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

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The support plan for resident #1, dated /24 indicated that Resident #1 "is aware of most hazardous materials" and "DCS will monitor resident's ability to distinguish and utilize poisonous materials. Any decline in ability will be reported to the physician and if applicable, poisonous materials will be safeguarded." On 25 at approximately 3:30 p.m., direct care staff person A found resident #1 eating Zinc Barrier Cream from the tube by hand in resident room belonging to resident #2 at the time of the incident. However, on 7/2/25 multiple items with poison safety labels were identified unlocked, unattended, and accessible in multiple resident bathrooms and the poisonous materials were not safeguarded.

Plan of Correction ***Directed - 07/23/2025)***

a revised/new Resident Support Plan was adjusted to reflect resident cannot distinguish the differences between hazardous and poisonous materials. All creams, medications, lotions, liquids with warning labels were removed from resident's rooms and kept in med cart. No resident may self-administer medications in the community. A audit tool was developed and is used each shift to verify by the med-tech that there are no chemicals in the rooms or general area accessible to residents. All education will be kept in employee's files

Responsible parties: administrator/med tech each shift

Proposed Overall Completion Date: 07/18/2025

DIRECTED
Within five days of receipt of the plan of correction: The administrator shall educate all staff persons regarding the regulation and the home's policy and procedures regarding regulatory compliance. Documentation of education will be kept in accordance with Regulation 2600.65(7/23/25

Directed Completion Date: *07/28/2025* *Not Implemented - 10/07/2025)*

82c - Locking Poisonous Materials

3. 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 7/2/25 at approximately 9:10 a.m. there was a fourteen-ounce tub of Aquaphor with a safety warning that indicated "If swallowed, get medical help or contact a Poison Control Center right away: This is crucial, especially if a large amount is ingested" as well as two open tubes of Desitin Maximum Strength Paste with a safety warning that indicated "If swallowed, get medical help or contact a Poison Control Center right away: Ingesting this product may be harmful. US residents can call 1-800-222-1222 to reach their local poison control center. Canada residents should call a provincial poison control center" and a four-ounce bottle of Sparkle Fresh Mouthwash with approximately one-third of the liquid remaining with a safety warning label that indicated "Seek professional help in case of accidental ingestion: If accidental ingestion occurs, immediately seek professional assistance or contact a Poison Control Center." All of the items were found on a black wire rack shelf labeled for resident #3 in the shared bathroom between resident room ■ belonging to resident #4 and resident room #15, which was unoccupied. On ■/25/25 at approximately 3:30 p.m., direct care staff person A found resident #1 eating Zinc Barrier Cream from the tube by hand in resident room ■ belonging to resident #2 at the time of the incident. Resident #1 cannot safely use or avoid poisonous materials and is still a resident of the personal care home.

On 7/2/25 at approximately 9:36 a.m., there was a thirty-two-ounce bottle of Comet Spray with bleach that was

82c - Locking Poisonous Materials (continued)

approximately one-fifth full hanging on a shelf behind the toilet in the shared bathroom between resident room belonging to resident #5 and resident room which was unoccupied, that had a safety warning label that indicated, "Ingestion: Call a poison control center immediately. If the person can swallow, have them sip a glass of water. Do not induce vomiting unless instructed by a medical professional" as well as a ten-ounce canister of Lysol spray that was almost entirely empty but had a safety warning label that indicated, "Ingestion: Do not induce vomiting. Rinse the mouth with water and call a physician or Poison Control Centre immediately." On 5/25 at approximately 3:30 p.m., direct care staff person A found resident #1 eating Zinc Barrier Cream from the tube by hand in resident room belonging to resident #2 at the time of the incident. Resident #1 cannot safely use or avoid poisonous materials and is still a resident of the personal care home.

Plan of Correction ***Directed - 07/23/2025)***

An audit was conducted of all resident rooms and developed to track any potential hazardous or poisonous materials in resident's rooms. This audit tool will be used at the beginning of each shift. All such items were removed from rooms and were placed under lock and key. Poisonous materials shall be kept locked and inaccessible to residents at all times. Please see attached audit that will be conducted each shift daily for 6 months

Responsible parties:

Proposed Overall Completion Date: 07/18/2025

DIRECTED
Within five days of receipt of the plan of correction: The administrator shall educate all staff persons regarding the regulation and the home's policy and procedures for locking poisonous materials. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 7/23/25

Directed Completion Date: *07/28/2025* *Not Implemented - 10/07/2025)*

141a 1-10 Medical Evaluation Information

4. 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. 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 #3's medical evaluation, dated /25 did not include the resident's body positioning / movement needs, that section of the form was left incomplete.

141a 1-10 Medical Evaluation Information (continued)

REPEAT VIOLATION 1/23/25 et. al.

Plan of Correction ***Directed - 07/23/2025)***

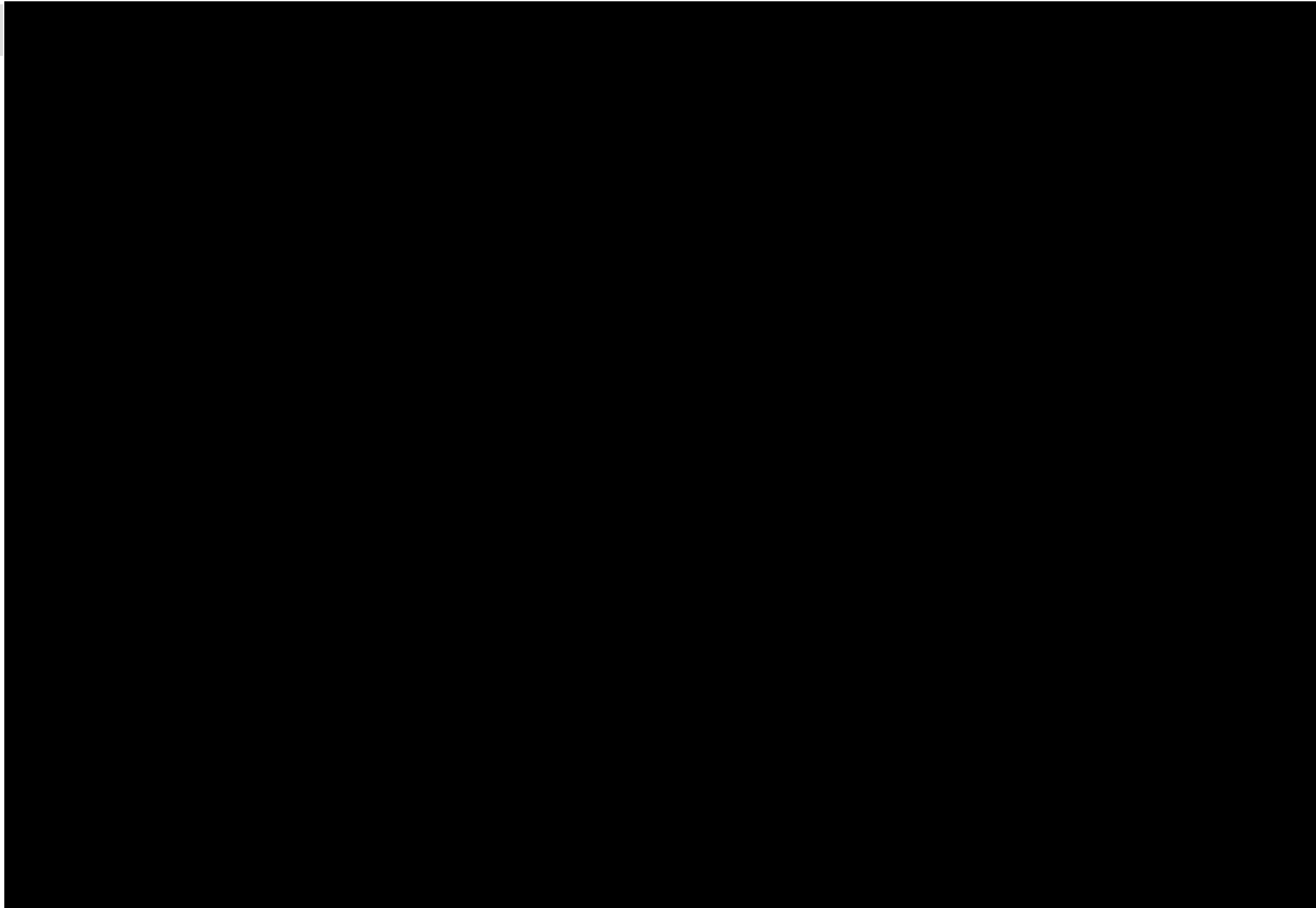
On the DME form dated /2025 section 8 did not include body positioning. This resident is currently in Mon Valley , with a prospective return date in approximately 2 weeks. We have faxed a new DME over to the facility requesting a new DME specifically on that section, but fully completed.
The resident returned on July th and a new DME was completed and returned with . Web have developed an audit tool that will be used weekly to audit all charts of residents to make sure the assessments are accurate and up to date by Administrator or house manager and kept in a binder.

Responsible parties:

Proposed Overall Completion Date: 07/18/2025

DIRECTED
Within five days of receipt of the plan of correction: The administrator shall educate the staff persons responsible for maintaining compliance with the regulation and the home's policies and procedures to ensure compliance. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 7/23/25

Directed Completion Date: *07/28/2025* *Not Implemented - 10/07/2025)*



141b2 - Medical Evaluation Changes *(continued)*

Directed Completion Date: *07/28/2025*

Implemented - 10/07/2025)

182b - Prescription Medication

6. Requirements

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

Resident #6's medical evaluation, dated 3/25, indicated the resident is unable to self-administer medication. The resident's support plan, dated /25, indicated "Resident #6 cannot administer own medications" and "Trained staff will administer resident #6's medications per physician's orders." Resident #6 is prescribed Refresh Celluvisc 1% eye drops, instill 1 drop into each eye three times a day. However, on 7/2/25, resident #6 indicated administered own eye drops and direct care staff person C indicated the resident self-administers the eye drops under the supervision of direct care staff.

Plan of Correction ***Directed - 07/23/2025)***

Informed resident and resident's family members that all medications including eye-drops must be administered by a med-tech and not by the resident. WE removed eyedrops from room and they are stored in the med-cart and administered according to the prescription. An audit tool was developed to track medications. It will be used daily to ensure there are no medications in the resident's rooms for 6 months Audits will be conducted by administrator or designee.

Responsible parties:

Proposed Overall Completion Date: 07/18/2025

DIRECTED
Within five days of receipt of the plan of correction: The administrator shall educate the staff persons responsible for maintaining compliance with the regulation and the home's policies and procedures to ensure compliance. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 7/23/25

Directed Completion Date: *07/28/2025*

Implemented - 10/07/2025)

183b - Meds and Syringes Locked

7. 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

At approximately 9:10 a.m. in the jack and jill bathroom between resident room and resident room

183b - Meds and Syringes Locked (continued)

was a fourteen-ounce open container of Aquaphor ointment as well as two-tubes of Desitin Maximum Strength Paste on a black wire shelf labeled for resident #3 that were found unlocked, unattended, and accessible.

Plan of Correction ***Directed - 07/23/2025)***

All medications ointments, cremes OTC, prescription, CAM syringes will be kept and locked in the med-cart and not in the resident's room. An audit of each room is performed each shift each day to make sure there are none left or in their room.

Responsible parties:

Proposed Overall Completion Date: 07/18/2025

DIRECTED
Within five days of receipt of the plan of correction: The administrator shall educate the staff persons responsible for maintaining compliance with the regulation and the home's policies and procedures to ensure compliance. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 7/23/25

Directed Completion Date: *07/28/2025* *Not Implemented - 10/07/2025)*

225c - Additional Assessment

8. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
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 #1's assessment, dated /24, was not updated to reflect a change in the resident's ability to safely use or avoid poisonous materials, however, on /25 at approximately 3:30 p.m., direct care staff person A found the resident eating Zinc Barrier Cream from the tube by hand in resident room #9 belonging to resident #2 at the time of the incident. Additionally, the medical evaluation for resident #1, dated /24, indicated the special health need of a "Brain Stimulator" and direct care staff person C indicated staff place the device around the back of the resident's neck to stimulate the brain, but the device was not documented in the resident's assessment.

Plan of Correction ***Directed - 07/23/2025)***

the doctor will complete a new assessment by July 17th of resident's abilities and complete a new DME, that will accompany the modified RASP completed by administrator. It will identify his inability to distinguish hazardous and poisonous materials. All audits will start July 18th and will be performed weekly for assessments for accuracy and up to date information by administrator or designee for 6 months. Education performed with designees by administrator and kept in their files

Responsible parties:

Proposed Overall Completion Date: 07/18/2025

DIRECTED
Within five days of receipt of the plan of correction: The administrator shall educate the staff persons responsible

225c - Additional Assessment (continued)

for maintaining compliance with the regulation and the home's policies and procedures to ensure compliance. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 7/23/25

Directed Completion Date: *07/28/2025*

Implemented - 10/07/2025)

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

Facility Information

Name: *VIDA SPRINGS SENIOR LIVING AND PERSONAL CARE HOME* **License #**: *45541* **License Expiration**: *12/18/2025*

Address: *1378 FOURTH STREET, MONONGAHELA, PA 15063*

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

Administrator

Name:

Legal Entity

Name: *VIDA SPRINGS SENIOR LIVING & PERSONAL CARE HOME, MONONGAHEL*

Address:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/13/2023* **Issued By**: *Carroll Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *16* **Waking Staff**: *12*

Inspection Information

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

Reason: *Complaint, Provisional, Monitoring* **Exit Conference Date**: *08/27/2025*

Inspection Dates and Department Representative

08/19/2025 - On-Site:
08/27/2025 - On-Site:
08/19/2025 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *28* **Residents Served**: *10*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *10*

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

Have Mobility Need: *6* **Have Physical Disability**: *0*

Inspections / Reviews

08/19/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/14/2025*

09/15/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/03/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/22/2025*

09/29/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/03/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/03/2025*

10/07/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *10/03/2025*

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

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 8/19/25 at approximately 11:05 a.m., there were multiple binders sitting unlocked, unattended, and accessible on a white folding table near the living room area to the left of the entrance to the home with protected health information for the home's residents to include:

Communication Logs dated 7/29/25 through 8/19/25 indicated:

- *Hospice care details for resident #1, dated 8/18/25 and 8/19/25*
- *Accident and medication details for resident #2, dated 8/17/25*
- *Insulin administration details for resident #3, dated 8/15/25*

Narcotic Log Book with narcotic count sheets for:

- *Resident #1 – Lorazepam 0.5mg tablet and Morphine Sulfate Solution 100/5mL*
- *Resident #2 – Morphine Sulfate Solution 20mg/1mL*
- *Resident #4 – Hydrocodone APAP 5/325mg tablet*

A purple folder labeled "Med refill" that contained medication list delivery sheets with the names and prescriptions of the home's resident's to include:

Resident #2's:

- *Vitamin D3 1000IU tablet*
- *Quetiapine 25mg tablet*
- *Cephalexin 250mg tablet*
- *Levothyroxine 25mcg tablet*

Resident #5's:

- *Melatonin 10mg tablet*
- *Hydralazine 25mg tablet*
- *Potassium Chloride 20meq tablet*
- *Amlodipine 10mg tablet*

Resident #6's:

- *APAP 500mg caplet*
- *Finasteride 5mg tablet*
- *Furosemide 40mg tablet*
- *Melatonin 10mg tablet*

Resident #7's:

- *Potassium Chloride 10meq capsule*
- *Bumetanide 2mg tablet*
- *Quetiapine 50mg tablet*

And a binder of shower schedules with individual shower sheets for:

- *Resident #3, dated 8/18/25*
- *Resident #8, dated 8/2/25, 7/17/25, and 7/8/25*

17 - Record Confidentiality (continued)

- *Resident #9, dated 7/16/25*

REPEAT VIOLATION 1/23/25 et. al.

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

A large 3 drawer locking file cabinet was purchased to house all binders including communication book, narcotics log, any prescriptions and all correspondence that contains resident information. This cabinet allows the med tech and other authorized personnel to access the resident's information while it's readily close to the Med Cart. The key is on the med-cart keys , so only the administrator and med tech have access. Education shall be kept in staff members file according to PA 2600.17. Education was conducted by [redacted] on policy and PA reg 2600.17

***A large locking cabinet was purchased to house Resident information that cannot be stored in the office. It is locked at all times except while in use and the keys are on the med cart. This was completed 9/4/2025 by [redacted]*

Please find a daily audit to be conducted by [redacted] beginning on sept 29th by [redacted] or [redacted] owner each day. Please find the Vida policy for Records Confidential and education sign in sheet.

Responsible parties: administrator [redacted]

Proposed Overall Completion Date: 09/16/2025

DIRECTED
Within four days of receipt of the plan of correction: The administrator shall educate all staff persons on the regulation and the home's policy and procedures to maintain compliance. Documentation shall be kept in accordance with Regulation 2600.65(i) [redacted] 9/29/25

Within one day of receipt of the plan of correction: The administrator shall ensure documentation of audits shall be kept for review. [redacted] 9/29/25

Directed Completion Date: *10/03/2025*

Implemented [redacted] - 10/07/2025)

25a - Written Contract and Review

2. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

The resident-home contract for resident #2, dated [redacted]/24, was signed by the resident and the home's administrator but neither signature was dated.

25a - Written Contract and Review (continued)

The resident-home contract for resident #4, dated /24, was signed by the resident and the home's administrator but neither signature was dated.

REPEAT VIOLATION 1/23/25 et. al.

Plan of Correction ***Directed - 09/29/2025)***

The administrator or designee are responsible for the correct execution of the contract. The contract between Resident #2 dated /24 was signed by the resident and the home's previous administrator but neither signature was dated, The resident home contract for resident #4 dated /24 was signed by the resident and the home's previous administrator but neither signature was dated.

The current administrator signed and dated both contracts and had the residents date the contract with the current dates of 9/13/2025, and 9/14/2025. A audit monitor tool was developed to check the contracts for all applicable signatures and completeness once per month beginning 9/29/2025, and will be performed by Inservice sheets will be kept in employees files.

Responsible parties:

Proposed Overall Completion Date: 09/29/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall audit all resident contracts to ensure all resident contracts are complete, signed, and dated appropriately. 9/29/25

Directed Completion Date: *09/30/2025* *Not Implemented - 10/07/2025)*

42s - Privacy

3. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The hallway wall to the left of the door outside of resident room #2 belonging to resident #9 had a window-like cut out with a reflective glass material within, however, the reflective glass was not entirely opaque, and did not provide privacy and passersby could see directly into the resident's bedroom.

REPEAT VIOLATION 1/23/25 et. al.

Plan of Correction ***Directed - 09/29/2025)***

An in-service was held by) to educate all staff on resident rights regarding the right to Privacy of self possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures. documentation of training will be kept in accordance with reg. 2600.65 (i)

A privacy screen was installed permanently and immediately. Please see attached photo.

An audit/monitoring tool was developed to track privacy in each resident's room and will be completed by on a weekly basis starting Sept 17th,

42s - Privacy (continued)

Proposed Overall Completion Date: 09/18/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall audit the home weekly to ensure all residents have the privacy of self and possessions. Privacy is provided to the resident during bathing, dressing, changing and medical procedures. 9/29/25

Directed Completion Date: *09/18/2025*

Implemented ███ - 10/07/2025)

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

Direct care staff person A was hired on ███/24. However, direct care staff person A did not have proof of permanent residency in Pennsylvania for the two consecutive years prior to beginning employment or a report of federal criminal history record information from the Federal Bureau of Investigation (FBI) 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.)

Direct care staff person B was hired on ███/24. However, direct care staff person B did not have proof of permanent residency in Pennsylvania for the two consecutive years prior to beginning employment or a report of federal criminal history record information from the FBI 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.)

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

All three people ███)went to the Identogo center on Library Road on 9/18/2025, and 9/17/2025 to be fingerprinted, and the FBI check in accordance with the Department of Aging's policy. please see the attached receipt form Identogo.

Responsible parties: ███

Vida Springs Senior Living Policy for Criminal History Checks:

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).

We have implemented a mechanism to ensure that all required information is collected from each applicant during the hiring process. This includes obtaining an FBI background report for any applicant who has resided in

51 - Criminal Background Check (continued)

Pennsylvania for less than two years.
To facilitate this, we have established an account with the Pennsylvania Department of Aging and IdentoGO, enabling us to conduct FBI screening reports directly through the approved system. This ensures accuracy, timeliness, and full compliance with state regulations.
(a) Procedural Steps for Compliance
1. Applicant Intake – All applicants complete a standardized intake form that captures personal details, employment background, and residency history.
2. Residency Verification – The intake form is reviewed to determine whether the applicant has lived in Pennsylvania for at least two (2) consecutive years.
3. Background Screening –
o Applicants who have lived in Pennsylvania for two years or more will undergo a Pennsylvania state criminal background check.
o Applicants who have lived in Pennsylvania less than two years will undergo both the Pennsylvania state criminal background check and an FBI background check.
4. FBI Screening Process – Applicants requiring FBI screening are directed to complete fingerprinting through IdentoGO using our registered account with the Department of Aging. All FBI reports are requested and tracked through this system.
5. Documentation & Recordkeeping – Copies of all background checks (state and/or FBI) are securely stored in the applicant's personnel file. A tracking log is maintained to confirm that all screenings are completed before the applicant is cleared up for hire.
6. Quality Assurance – The Administrator or designee reviews every applicant's file prior to approval to ensure that all required background checks are completed and documented. No applicant is permitted to begin employment until full compliance is verified.
(b) Compliance Monitoring
To ensure ongoing compliance, the Administrator (or designee) will conduct a monthly audit of all new applicant files. The audit will confirm that:
? Residency history is properly documented.
? The correct type of background check (state and/or FBI) was completed.
? Background screening results are filed and logged prior to the applicant starting employment Any discrepancies identified during the audit will be immediately corrected. If necessary, intake staff will be retrained to prevent recurrence. Audit results will be documented and reviewed quarterly during Quality meetings to maintain consistent and sustainable compliance.

Responsible parties: Administrator, owner, designee

Licensee's Proposed Overall Completion Date: *09/22/2025*

Implemented █ - 10/07/2025)

81b - Resident Personal Equipment

5. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

81b - Resident Personal Equipment *(continued)*

Description of Violation

On 8/19/25 at approximately 12:02 p.m. the left brake control on resident #3's rollator was broken completely off and found resting on the resident's white 4-drawer dresser in resident room ███

REPEAT VIOLATION 12/16/24

Plan of Correction ***Directed ███ - 09/29/2025)***

New resident's ███ brought ███ rollator in from home. The next day the physical therapist attempted to demonstrate how to use it and broke the handle.

***The rollator was removed from ███ room on August 19th, 2025 by ███)*
An audit will be developed to monitor resident's personal equipment that they have in the room each week to make sure it's all in good working order to monitor all resident's equipment on a weekly basis.

An In-service was conducted on Resident's personal equipment 260081b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards with all staff conducted by ███) on Sept 18, 19, 2025. audits beginning sept 22, 2025 weekly

Responsible parties: ███

Proposed Overall Completion Date: 09/20/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall ensure the education of staff regarding the regulation is maintained in accordance with Regulation 2600.65(i). ███ 9/29/25

Within one day of receipt of the plan of correction: The administrator shall ensure documentation of audits shall be kept for review. ███ 9/29/25

Directed Completion Date: *09/30/2025* *Not Implemented ███ - 10/07/2025)*

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 8/19/25 there were as many as 18 unlocked and unattended poisonous materials located in various areas of the home that indicated in case of accidental ingestion, get medical help or contact a Poison Control Center right away to include:

- *One-Gallon bucket of Behr semi-gloss cabinet door and trim enamel*
- *Multiple 4-ounce tubes of A&D Ointment*
- *Multiple 4-ounce tubes of Zinc Oxide Remedy Paste*
- *Multiple 4-ounce bottles of Medline Sparklefresh Mouthwash*
- *Multiple 1.5-ounce McKesson roll-on Anti-Perspirant Deodorant sticks*
- *Multiple aerosol cleaning sprays*

82c - Locking Poisonous Materials (continued)

- *4 individual Members Mark Laundry Power Pacs laundry detergent pods*
- *1 Open Container of Cascade Complete dishwasher detergent pods*
- *1 102-ounce bottle of Palmolive Ultra AntiBacterial dish liquid*

Resident #10 was not assessed as able to safely use and avoid poisonous materials.

Plan of Correction ***Directed - 09/29/2025)***

Locks were purchased for the laundry room, janitor's closet, and kitchen cabinets that contain and house poisonous materials. There were items left out from hospice in the closet so there is a file cabinet next to the med cart that house their supplies.

Responsible parties:

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within four days of receipt of the plan of correction: The administrator shall educate all staff persons on the regulation and the home's policy and procedures to maintain compliance. Documentation shall be kept in accordance with Regulation 2600.65(i) 9/29/25

Within one day of the receipt of the accepted plan of correction: The administrator or designated staff person shall conduct weekly audits of the home to ensure poisonous materials are not accessible to the residents. Documentation of audits shall be kept for review. 9/29/25

Directed Completion Date: *10/03/2025* *Not Implemented - 10/07/2025)*

89b - Hot Water Temperature

7. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 8/19/25 at approximately 10:35 a.m., the hot water temperature at the hand sink in the shared bathroom between resident room belonging to resident #2 and the vacant resident room measured 161.7 degrees Fahrenheit.

On 8/19/25 at approximately 10:55 a.m., the hot water temperature at the hand sink located in the home's kitchenette off the dining area measured 158.9 degrees Fahrenheit.

Plan of Correction ***Directed - 09/29/2025)***

A plumber was hired to adjust the water heaters and the different zones in the building will be monitored daily for temperatures not to exceed 120 degrees F by)

Water thermometers were ordered to monitor the water temperature. There was construction in parts of the building and new water heaters were installed. No one monitored the temperature. The construction was completed and the water heaters have been adjusted down to 115 degrees and will be monitored weekly with the new thermometers to maintain the temperature

89b - Hot Water Temperature (continued)

Responsible parties: ████

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within four days of receipt of the plan of correction: The administrator shall educate all staff persons on the regulation and the home's policy and procedures to maintain compliance. Documentation shall be kept in accordance with Regulation 2600.65(i) █ *9/29/25*

Within one day of receipt of the plan of correction: The administrator shall ensure documentation of weekly audits shall be kept for review. █ *9/29/25*

Directed Completion Date: *09/30/2025*

Implemented* █ *- 10/07/2025)

95 - Furniture and Equipment

8. Requirements

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

Description of Violation

On 8/19/25 at approximately 11:43 a.m., the keypad locking mechanism to the home's housekeeping and janitor's closet was operational, however, the deadbolt of the locking mechanism would not align with the strike plate of the door frame and after repeated attempts the door could not be locked.

Plan of Correction ***Directed (* █ *- 09/29/2025)***

A new key lock was installed immediately, and the key is located on the med keys.
All equipment such as locks, furniture, appliances will be monitored for good working order. If any equipment is not working or is damaged, it shall be removed from service immediately and repaired or replaced. The owner Chris will be in charge of this and the audits will begin September 29th and will be conducted weekly.

Responsible parties: ████

Proposed Overall Completion Date: 09/29/2025

DIRECTED
Within four days of receipt of the plan of correction: The administrator shall educate all staff persons on the regulation and the home's policy and procedures to maintain compliance. Documentation shall be kept in accordance with Regulation 2600.65(█ *9/29/25*

Within one day of receipt of the plan of correction: The administrator or designated staff person shall audit the home weekly to ensure furniture and equipment are in good repair, clean and free of hazards. Documentation of audits shall be kept for review. █ *9/29/25*

Directed Completion Date: *10/03/2025*

Implemented* █ *- 10/07/2025)

95 - Furniture and Equipment *(continued)*

101r - Bedroom - shades/drapes/window covering

9. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

On 8/19/25, the windows in the following locations had sheer curtain coverings that did not provide privacy to include:

- *Resident room #7 belonging to resident #3*
- *Resident room #5 belonging to resident #8*
- *Resident room #2 belonging to resident #9*
- *Resident room #4 belonging to resident #10*

Plan of Correction ***Directed - 09/29/2025)***

A monitoring tool was developed to check each week to make sure there are adequate window coverings starting Sept 22
Darkening drapes or curtains were purchased for ALL rooms and installed before the surveyors returned on August 27. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Please see pictures of the drapes on rooms #7, 5, 2, and 4.
Responsible party:

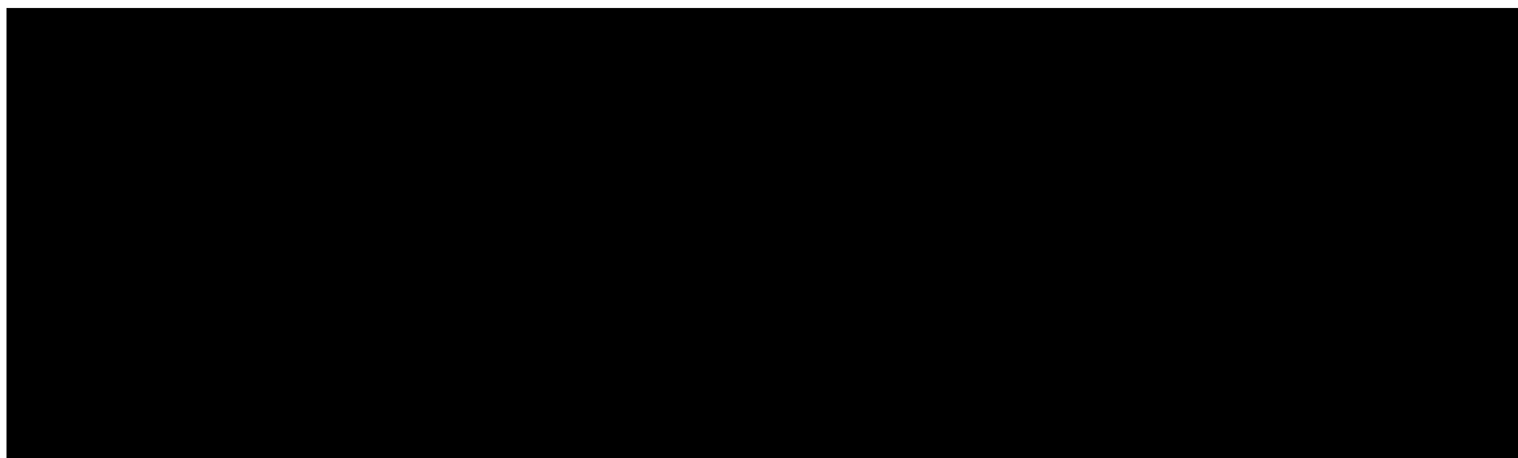
Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within four days of receipt of the plan of correction: The administrator shall educate all staff persons on the regulation and the home's policy and procedures to maintain compliance. Documentation shall be kept in accordance with Regulation 2600.65(i) 9/29/25

Within one day of receipt of the plan of correction: The administrator or designated staff person shall audit the home weekly to ensure there are be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must are clean, in good repair, and provide privacy and cover the entire window when drawn. Documentation of audits shall be kept for review. /29/25

Directed Completion Date: *09/24/2025*

Implemented - 10/07/2025)



103g - Storing Food

11. Requirements

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

Description of Violation

On 8/19/25 at approximately 10:50 a.m., in the home's kitchenette off the dining area, there was a five-pound bag of Members Mark shredded 5-cheese Mexican blend that contained approximately 3 pounds of cheese and was found open and unsealed in the refrigerator portion of the home's Frigidaire refrigerator and freezer.

Plan of Correction ***Directed - 09/29/2025)***

The bag of cheese was discarded immediately 8/19/2025 by . An Inservice was held for staff and documented in accordance with 2600.65 (i)

All staff were inserviced on the proper storage of food. This particular refrigerator is in the common area which the resident's and staff utilize to store food. All food must be labeled with the date, time and initials if it is opened. The cooks are responsible for checking all fridges daily and completing an audit, checking all food items for dates and discarding items that are not labeled or do not contain all the information described in 2600 103.g.

Responsible parties: Administrator, cooks, owners and RCC

103g - Storing Food (continued)

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall ensure documentation of daily audits are kept for review. 9/29/25

Directed Completion Date: *09/30/2025*

Not Implemented - 10/07/2025)

105g - Lint Removal and Duct Cleaning

12. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 8/19/25 at approximately 11:42 a.m., there was an approximate one-quarter inch accumulation of lint in the lint trap of the home's General Electric dryer. Additionally, the lint was divided into separate one-eighth-inch thick layers, one was dark grey lint with leaf debris, and the other layer was light grey lint and both layers could be separated.

Plan of Correction ***Directed - 09/29/2025)***

An audit tool was developed to monitor lint removal each day. Monitoring shall start Sept 26th

Staff was educated on the importance of removing lint that could start a fire. All staff should be in serviced by Sept 11th. Please see attached training sheet.

Responsible parties:

Proposed Overall Completion Date: 09/26/2025

DIRECTED
Immediately: The administrator shall remove the lint from the clothes dryer cited in the violation. 9/29/25

Within one day of receipt of the plan of correction: The administrator shall ensure the education of staff regarding the regulation is maintained in accordance with Regulation 2600.65(i). 9/29/25

Within one day of receipt of the plan of correction: The administrator shall ensure documentation of weekly audits shall be kept for review. 9/29/25

Directed Completion Date: *09/30/2025*

Implemented - 10/07/2025)

132d - Evacuation

13. Requirements

2600.

132d - Evacuation *(continued)*

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

On 1/31/25 at 1:12 p.m. the home conducted a fire drill with an evacuation time of 7 minutes and 41 seconds. However, there was no maximum safe evacuation time documented in writing by a fire safety expert and the default time was 2 minutes and 30 seconds.

On 3/28/25 at 6:20 a.m. the home conducted a fire drill with an evacuation time of 5 minutes and 31 seconds. However, the documentation of the supervised inspection by a fire safety expert, dated 2/3/25, indicated a safe evacuation time of 3 minutes and 0 seconds.

On 4/30/25 at 6:49 p.m. the home conducted a fire drill with an evacuation time of 3 minutes and 56 seconds. However, the documentation of the supervised inspection by a fire safety expert, dated 2/3/25, indicated a safe evacuation time of 3 minutes and 0 seconds.

On 5/31/25 at 1:21 p.m. the home conducted a fire drill with an evacuation time of 3 minutes and 54 seconds. However, the documentation of the supervised inspection by a fire safety expert, dated 2/3/25, indicated a safe evacuation time of 3 minutes and 0 seconds.

On 6/27/25 at 3:09 p.m. the home conducted a fire drill with an evacuation time of 3 minutes and 47 seconds. However, the documentation of the supervised inspection by a fire safety expert, dated 2/3/25, indicated a safe evacuation time of 3 minutes and 0 seconds.

On 7/8/25 at 3:30 p.m. the home conducted a fire drill with an evacuation time of 3 minutes and 50 seconds. However, the documentation of the supervised inspection by a fire safety expert, dated 2/3/25, indicated a safe evacuation time of 3 minutes and 0 seconds.

Plan of Correction ***Directed ███ - 09/29/2025)***

*** The Fire Chief returned on Sept 18th and suggested 3 alternatives to increase our getting our residents out in 3 minutes.*
a) increase the staff to be able to escort the residents out safely
b) get fire doors on each side of the common area
c) add sprinkler system.

We elected to add more staff. We have 3 "lodgers" that live on the premises. They will be required to assist during an evacuation on fire alarm. We have hired 3 additional staff to work to replace staff. We will have a fire drill on September 30th to monitor the times and to be in accordance with the instructions set above.

The Fire Chief from ███ was contacted to come back to our facility to re-evaluate the time that it will take and is necessary for a safe and proper evacuation. ███ will conduct a supervised Fire drill on September 30th. We have also addressed staff on how to properly evacuate residents in a safe and speedy manor. We are attempting to lower our evacuation time and with his guidance we should achieve our goal.

Responsible Parties: ███

132d - Evacuation (continued)

Proposed Overall Completion Date: 09/30/2025

DIRECTED
Immediately: The administrator shall schedule the appropriate number of staff on all shifts to meet the safe evacuation time specified by the home's fire safety expert. ██ 9/29/25

Immediately: The administrator or designee shall audit the fire drill record monthly to ensure an unannounced fire drill shall be held at least once a month to ensure residents are evacuated from the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert.

Immediately: The administrator shall complete the following necessary steps to reduce the safe evacuation to a time less than 2 minutes and 30 seconds or the safe evacuation time specified by the home's fire safety expert within the past year:
- *Provide resident and staff education on evacuation policies and procedures. Documentation will be kept.*
- *Relocate residents who require special assistance with evacuation closer to exits or fire-safe areas.*
- *Request a decrease in licensed capacity and discharge residents in order to meet the safe evacuation time.*

██ 9/29/25

Directed Completion Date: *09/30/2025* *Not Implemented ██ - 10/07/2025)*

141b1 - Annual Medical Evaluation

14. Requirements

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

Description of Violation

Resident #2's most recent medical evaluation was dated ███/24.

Resident #4's most recent medical evaluation was dated ███/24.

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

Audits will be conducted by ██████) beginning Sept 22nd and will be conducted bi-weekly. The audits will be kept in an audit book in the office

Both resident 2 and 4 are on hospice. We were able to obtain a current DME for them although it was past the one year time-frame. An audit was developed to audit each chart monthly to make sure we have a new yearly DME. Please see attached

Licensee's Proposed Overall Completion Date: *09/24/2025* *Not Implemented ██ - 10/07/2025)*

162c - Menus Posted

15. Requirements

162c - Menus Posted *(continued)*

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 8/19/25 at approximately 11:05 a.m., the home's menu for the week of 7/14/25 was posted. However, the current and following week's menus were not posted in a conspicuous and public place in the home.

Plan of Correction ***Directed - 09/29/2025)***

This started on 9/11/2025The menus have been hung and an audting tool was developed to monitor the menus each week. They will be checking for at least 2 menus to be hung including the current week and the following week. Currently we have 4 weeks hung. The Cook are in charge of the audit each week. All staff was educated in accordance with 2600.65(i) and kept in files

The auditing tool will ensure there are two menus hung each week. One for the current week and one for the following week.

Four weeks' worth of menus have been created and they will be rotated each 4th week in addition to our all-available menu

Responsible party:

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall ensure documentation of audits shall be kept for review. 9/29/25

Directed Completion Date: *09/24/2025*

Implemented - 10/07/2025)

183b - Meds and Syringes Locked

16. Requirements

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

Description of Violation

On 8/19/25 at approximately 12:05 p.m. there were two un-opened bottles of Milk of Magnesia as well as a bottle of Lactulose solution with pharmacy labels that indicated the medication belonged to resident #8 that were found unlocked, unattended, and accessible in the shared bathroom between resident room belonging to resident #3 and resident room belonging to resident #8.

Plan of Correction ***Directed - 09/29/2025)***

All medications were gathered from the resident's room and placed in the med carts and we obtained an order for them from our house MD. All staff were educated and an audit was developed to monitor the rooms on a daily basis to make certain family members are not bringing in medication. All staff were educated and kept in their file

183b - Meds and Syringes Locked (continued)

Responsible parties: [redacted]

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall ensure the education of staff regarding the regulation is maintained in accordance with Regulation 2600.65(i). [redacted] *9/29/25*

Within one day of receipt of the plan of correction: The administrator shall ensure documentation of audits shall be kept for review. [redacted] *9/29/25*

Directed Completion Date: *09/30/2025*

Not Implemented [redacted] ***10/07/2025)***

183d - Prescription Current

17. Requirements

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

Description of Violation

Resident #8 was prescribed Ibuprofen 600mg tablets, however, sometime during the month of April 2025, the prescription was changed to Ibuprofen 800mg tablets, and a new pharmacy card was dispensed on 4/21/25. However, on 8/27/25 at approximately 1:48 p.m. there was a blister pack of Ibuprofen 600mg tablets belonging to resident #8 found on the home's medication cart.

REPEAT VIOLATION 1/23/25 et. al.

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

We had a med cart audit conducted by our pharmacy Health Direct. This will occur once monthly , however we will conduct weekly audits. We corrected everything that was found on the audit performed by the health Direct consultant. Med techs were educated and will be kept in their file. The representative from Health Direct also provided education on proper medication labeling , current prescriptions and making sure the MAR matches the medicine

Responsible Party: [redacted]

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall ensure the education of staff regarding the regulation is maintained in accordance with Regulation 2600.65(i). [redacted] *9/29/25*

Within one day of receipt of the plan of correction: The administrator shall ensure documentation of audits shall be kept for review. [redacted] */29/25*

Directed Completion Date: *09/30/2025*

Not Implemented [redacted] ***- 10/07/2025)***

183d - Prescription Current *(continued)*

184a - Resident's Meds Labeled

18. Requirements

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

Description of Violation

Resident #3's Lantus Solostar 100UN/mL was in a plastic bag that had the resident's name and date opened but did not have a pharmacy label or instructions for administration. Resident #3 was prescribed Lantus Solostar 100UN/mL, inject 30 units subcutaneously once daily at bedtime.

Resident #3's Insulin Aspart 100UN/mL was in a plastic bag that had the resident's name and date opened but did not have a pharmacy label or instructions for administration. Resident #3 was prescribed Insulin Aspart 100UNIT/mL inject per sliding scale three times daily before meals: 131-180= 2U, 181-240= 4U, 241-300= 6U, 301-350=8U, 351-400= 10U, <400= 12U.

The pharmacy label for resident #8's Meclizine 12.5mg tablet indicated "Take 1 tablet by mouth three times daily." However, resident #8 was prescribed Meclizine 12.5mg, take 1 tablet by mouth three times daily as needed.

Resident #8's Trelegy Ellipta 100-62.5-25 Inhaler was present in resident room #5, however, there was no pharmacy label on the inhaler's packaging and the box with the pharmacy label could not be located.

Resident #10's open insulin Aspart quick pen injector was stored in a blue fabric bag with a zipper that did not include the pharmacy label with instructions for administration. Resident #10 was prescribed Insulin Aspart 100 UNIT/mL, inject subcutaneously before meals and at bedtime per scale: 0-140= 0U, 150-200= 4U, 201-250= 6U, 251-300= 8U, 301-350= 12U, 351-400= 14U, 401-450= 18U, 451+= 20U call MD.

Resident #10's open Lantus Solostar quick pen injector was stored in a blue fabric bag with a zipper that did not include the pharmacy label with instructions for administration. Resident #10 was prescribed Lantus Solostar 100UN/mL, inject 20 units subcutaneously daily.

Resident #10's entire supply of Lantus Solostar pens was stored in a large Ziplock plastic bag and did not have a pharmacy label.

REPEAT VIOLATION 1/23/25 et. al.

Plan of Correction ***Directed - 09/29/2025)***

All medications were audited for proper labeling adhering to the 4 areas of proper name, 2. name of medication 3. date meds were issued 4. prescribed dosage. All med tech's were inserviced and kept in their file.

Responsible parties:

184a - Resident's Meds Labeled (continued)

Proposed Overall Completion Date: 09/24/2025

DIRECTED

Within one day of receipt of the plan of correction: The administrator shall ensure the education of staff regarding the regulation is maintained in accordance with Regulation 2600.65(i). ██ 9/29/25

Within one day of receipt of the plan of correction: The administrator or designated staff person qualified to administer medications shall conduct a weekly audit of resident medications prescriptions to ensure the original container for prescription medications is labeled with an accurate pharmacy label. Documentation of audits shall be kept for review. ██ 9/29/25

Directed Completion Date: *09/30/2025*

Not Implemented ██ - 10/07/2025)

184b - Labeling OTC/CAM

19. 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 8/27/25 at 2:49 p.m. there was a used four-ounce tube of Desitin Max 40% Paste on the medication cart that was not labeled with the name of any resident and had approximately one ounce of paste remaining.

Plan of Correction ***Directed ██ - 09/29/2025)***

In service was held on labeling OTC with resident's name. education will be kept in accordance with PA 2600.65 (i)

We had our pharmacy conduct a cart audit and she found similar violations. WE have corrected the med cart and will be conducting a weekly audit. An inservice was held and kept in their files.
Responsible parties: ██████

Proposed Overall Completion Date: 09/24/2025

DIRECTED

Within one day of receipt of the plan of correction: The administrator shall ensure the education of staff regarding the regulation is maintained in accordance with Regulation 2600.65(i). ██9/29/25

Within one day of receipt of the plan of correction: The administrator shall ensure documentation of weekly audits shall be kept for review. ██ 9/29/25

Directed Completion Date: *09/30/2025* *Not Implemented ██ - 10/07/2025)*

185a - Implement Storage Procedures

20. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #3's OneTouch Ultra2 glucometer contained a reading of 166 bs/dL on 8/27/25 at 8:30 a.m., however, the reading was not recorded in resident #3's August 2025 medication administration record.

The home's procedures for medication administration did not include a procedure for safe storage, access, security, distribution and use of medical equipment. However, on 8/19/25 at approximately 11:05 a.m., there was a bag with a polka-dot pattern found on the heat register vents to the right of the home's medication cart in the living room area and the bag contained multiple boxes of lancets and glucose test strips with pharmacy labeling for resident #3.

Resident #8 was prescribed Oxycodone APAP 5-325mg, take 1 tablet by mouth every six hours as needed for severe pain. However, on 8/27/25, resident #8's Oxycodone tablets were not on the medication cart or in the home to administer if requested by the resident.

REPEAT VIOLATION 1/23/25 et. al.

Plan of Correction ***Directed - 09/29/2025)***

We had an audit conducted pf our MED cart by our pharmacy and they matched and verified every medication and made sure it matched the MAR. we will be conducting a weekly audit to verify and properly store medications.
Responsible Party:)

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall ensure the education of staff regarding the regulation is maintained in accordance with Regulation 2600.65(i). 9/29/25

Within one day of receipt of the plan of correction: The administrator shall ensure documentation of weekly audits of MARS (for accuracy and completeness), monitoring the home for accessible medications and medical supplies, and all prescribed medication are available shall be kept for review. 9/29/25

Directed Completion Date: *09/30/2025* *Not Implemented (- 10/07/2025)*

186a - Authorized Prescriber

21. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

The home had no record of a current signed order by an authorized prescriber for resident #8's Levothyroxine 75mcg, take one tablet by mouth every day, and the resident's pharmacy provided the written order for the prescribed medication that indicated electronically signed by an authorized prescriber on 5/19/25.

Plan of Correction ***Directed - 09/29/2025)***

We obtained the order from PCP and had it added to the MAR. We instructed all the med tech's to make certain the medications match the MAR and that a copy of the order is in the resident's chart. In order for it to be on the MAR, there has to be an order sent to the pharmacy, we just did not have a copy in the resident's chart.
Responsible Party:

186a - Authorized Prescriber (continued)

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within two days of receipt of the plan of correction: The administrator shall complete an initial audit of all current resident medication orders to ensure compliance with Regulation. Documentation of the audit shall be kept for review.[redacted] 9/29/25

Within four days of receipt of the plan of correction: The administrator shall educate all staff persons qualified to administer medications regarding the regulation and the home's policy and procedures to maintain compliance. Documentation of education shall be kept in accordance with Regulation 2600.65(i). [redacted] 9/29/25

Within two days of receipt of the plan of correction: The administrator or staff person qualified to administer medications shall complete a monthly audit of resident prescriptions to ensure compliance with the regulation. Documentation of audits shall be kept for review. [redacted] 9/29/25

Directed Completion Date: *10/03/2025* *Not Implemented [redacted] - 10/07/2025)*

187a - Medication Record

22. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #2's August medication administration record for Desitin Max 40% Paste, apply 2 ounces topically to bilateral buttocks daily did not indicate the diagnosis or purpose of the medication.

REPEAT VIOLATION 1/23/25 et. al.

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

We obtained a diagnosis of diaper rash for Resident #2 as needed by [redacted] 9/11/2025

As part of our medication audit, we are monitoring the medication recording of records. We will be looking for diagnosis and how often the medication should be administered.

Responsible Party: [redacted]

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within four days of receipt of the plan of correction: The administrator shall educate all staff persons on the regulation and the home's policy and procedures to maintain compliance. Documentation of education shall be kept in accordance in accordance with Regulation 2600.65(i),[redacted] 9/29/25

Within two days of receipt of the plan of correction: The administrator or designated staff person qualified to

187a - Medication Record (continued)

administer medication shall audit all resident medication records weekly to ensure accuracy and completeness. Documentation of audits shall be kept for review. █ 9/29/25

Directed Completion Date: *10/03/2025* *Not Implemented █ - 10/07/2025)*

187b - Date/Time of Medication Admin.

23. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2's Desitin Max 40% Paste, apply 2 ounces topically to bilateral buttocks daily was documented as administered by direct care staff person A on 8/27/25 at 8:00 a.m. However, direct care staff person A indicated direct care staff person C applied the Desitin Max 40% Paste during the previous shift and that he did not administer the medication but had signed the August 2025 medication administration record.

Resident #4's August 2025 medication administration record was not signed by the home's medication technicians who administered all of the resident's medications from 8/13/25 until 8/26/25.

Resident #8 is prescribed Lidocaine 4% Patch, apply topically to back at bedtime. However, on 8/18/25 at approximately 8:00 p.m., resident #8's August 2025 medication administration record did not document the administration of the Lidocaine 4% patch, and the Department was unable to determine whether the medication was administered or not due to the resident's frequently documented refusals of that medication.

REPEAT VIOLATION 1/23/25 et. al., 12/16/24

Plan of Correction ***Directed █ - 09/29/2025)***

As part of our medication audit, we are monitoring the medication recording of records. We will be looking for diagnosis and how often the medication should be administered.

Responsible Party: █

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within four days of receipt of the plan of correction: The administrator shall educate all staff persons on the regulation and the home's policy and procedures to maintain compliance. Documentation of education shall be kept in accordance in accordance with Regulation 2600.65(i),█ 9/29/25

Within two days of receipt of the plan of correction: The administrator or designated staff person qualified to administer medication shall audit all resident medication records weekly to ensure accuracy and completeness. Documentation of audits shall be kept for review. █ 9/29/25

Directed Completion Date: *10/03/2025*

Implemented █ - 10/07/2025)

187d - Follow Prescriber's Orders

24. Requirements

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

Description of Violation

Resident #8 was prescribed Levothyroxine 75mcg, take one tablet by mouth every day. The resident is assessed as able to self-administer medications but interviews indicated the home's staff administer the Levothyroxine 75mcg. However, resident #8 was not administered the Levothyroxine 75mcg tablet on dates to include:

- *8/1/25 through 8/6/25*
- *8/9/5*
- *8/12/25*
- *8/13/25*
- *8/18/25*
- *8/19/25*
- *8/24/25*

REPEAT VIOLATION 1/23/25 et. al., 12/16/24

Plan of Correction ***Directed - 09/29/2025)***

All med tech's were re -educated on following prescriber's orders. This will be part of the med cart audit.

Responsible Party:

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall ensure the education of staff regarding the regulation is maintained in accordance with Regulation 2600.65(i). 9/29/25

Within two days of receipt of the plan of correction: The administrator or designated staff person shall complete an initial medication audit of all prescribed medications including who (by title) completed the audit, and the date the audit will begin. Documentation of the audit shall be kept for review. 9/29/25

Within two days of receipt of the plan of correction: The administrator or designated staff person qualified to administer medications shall conduct a weekly audit all medication records to ensure accuracy and completeness. Documentation of audits shall be kept for review. 9/29/25

Within one day of receipt of the plan of correction: The administrator shall notify the resident and the resident's designated person of the medication errors for the resident. Documentation of the notifications shall be kept for review. 9/29/25

Within one day of receipt of the plan of correction: The administrator shall notify the prescriber of the medication errors for the resident and the home shall follow the direction of the prescriber related to the medication error. Documentation of the notification shall be kept for review. Documentation of the prescribers response or any further action shall be documented for review. 9/29/25

187d - Follow Prescriber's Orders (continued)

Within one day of receipt of the plan of correction: The administrator shall file an incident report for the medication errors. 9/29/25

Within one day of receipt of the plan of correction: The administrator shall document the medications errors as part of the resident's permanent record. 9/29/25

Directed Completion Date: *10/01/2025* *Not Implemented - 10/07/2025)*

190a - Completion Medication Course

25. 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

Direct care staff person D's initial medication administration training, dated /25, did not indicate that the staff person had completed observations with the certified trainer.

REPEAT VIOLATION 1/23/25 et. al.

Plan of Correction ***Directed - 09/29/2025)***

All med techs will be retr

All med tech's will be retrained by DHS approved Med Trainer on Sept 29th. will also train r to be a practicum observer so we have someone on the premises to perform observations

Proposed Overall Completion Date: 10/02/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall conduct an audit of all current staff records to ensure all staff administering medications meet the requirements to administer medications Documentation of the audit shall be kept. 9/29/25

Within one day of receipt of the plan of correction: The administrator shall conduct a quarterly audit to ensure these staff continue to meet the requirements to administer medications. Documentation of the audit shall be kept. 9/29/25

Directed Completion Date: *10/02/2025* *Not Implemented - 10/07/2025)*

190b - Insulin Injections

26. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

190b - Insulin Injections *(continued)*

Description of Violation

Direct care staff person A received diabetic education in the past 12 months, but the home did not maintain documentation or provide proof that the trainer was part of a Department-approved diabetes patient education program. Direct care staff person A has administered insulin multiple times to multiple residents of the personal care home during August 2025.

Plan of Correction ***Directed - 09/29/2025)***

All staff has been trained by a diabetic expert. Please see the certificates of those that completed training. An audit tool was developed to monitor each staff person every 6 months and all new as part of their new hire orientation.

The audit will be conducted by

Responsible parties:

All staff will be trained and certified by an instructor approved by the DHS on September 15th at 1:00pm. All education will be maintained in their files under lock and key. Allegedly the former administrator that recently left removed certificates of training and took them with . Therefore we are having all of our staff re educated.

Responsible parties:

Proposed Overall Completion Date: 09/24/2025

DIRECTED

Within one day of receipt of the plan of correction: The administrator shall conduct an initial audit of all staff records to ensure any staff persons administering insulin injections has successful completed a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months and the documentation is in each staff person's record. 9/29/25

Within one day of receipt of the plan of correction: The administrator shall ensure documentation of six month audits are kept for review. 9/29/25

Directed Completion Date: *09/30/2025*

Implemented - 10/07/2025)

221c - Post Activity Calendar

28. Requirements

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

221c - Post Activity Calendar *(continued)*

Description of Violation

The home did not have a current weekly activity calendar posted in a public and conspicuous place in the home. The activity calendar that was posted was dated June 2025.

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

A posted activity sheet will be posted each month on the 1st day of the month by the owner.

Responsible party:

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within four days of receipt of the plan of correction: The administrator shall educate all staff persons on the regulation and the home's policy and procedures to maintain compliance. Documentation of education will be kept in accordance with Regulation 2600.65(i). 9/29/25

Within four days of receipt of the plan of correction: The administrator shall audit the home weekly to ensure a current weekly activity calendar shall be posted in a conspicuous and public place in the home. Documentation of audits shall be kept for review. 9/29/25

Directed Completion Date: *10/03/2025*

Implemented - 10/07/2025)

251c - Standardized Forms

29. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident #1's medical evaluation, dated /25, was not documented on a form specified by the Department. The medical evaluation was documented on the Department's discontinued medical evaluation form.

Resident #10's medical evaluation, dated /25, was not documented on a form specified by the Department. The medical evaluation was documented on the Department's discontinued medical evaluation form.

REPEAT VIOLATION 1/23/25 et. al.

Plan of Correction ***Directed - 09/29/2025)***

At the time of completion of the "said" DME's, the administrator went to DHS website to download the form. downloaded and printed the form that was listed at the top. This form remained on the web-site until 8/19/2025, even though the latest form was on the site below the older DME. When this was brought to the attention of the state surveyor, immediately contacted superior and it was removed from the site that day. Going forward, prior to downloading any form, the administrator will verify the form to be the most recent and current form to be used. Those DME's will be signed by the doctor and replace the old form when returns on , 2025

Responsible parties: Administrator, owner

251c - Standardized Forms (continued)

Proposed Overall Completion Date: 09/24/2025

DIRECTED
Within four days of receipt of the plan of correction: The administrator shall obtain documentation of resident #1's and resident#10's medical evaluation on the form approved by the Department. The documentation shall be maintained in the residents records. █ 9/29/25

Within one day of receipt of the plan of correction: The administrator shall conduct an audit al resident records to ensure all medical evaluation documentation after 8/19/25 is documented on the Departments current form. Documentation of the audit shall be kept for review. █ 9/29/25

Directed Completion Date: *10/03/2025*

Implemented (█ - 10/07/2025)