



Pennsylvania Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 26, 2026

[REDACTED] Owner
Sterling Home LLC
[REDACTED]

RE: Sterling Home
1318 Arch Street
McKeesport, Pennsylvania 15132
License/COC #: 452694

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on June 24, 2025, August 20, 2025, August 25, 2025, September 3, 2025, and November 17, 2025, of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REFUSES to RENEW your certificate of compliance (license number 452694) dated June 4, 2025 – December 4, 2025, to operate the above facility. The Department's decision to REFUSE to RENEW your license is based on the violations attached to this notice and your failure to comply with the Department's regulations, mistreating or abusing individuals cared for in the facility, and failure to submit an acceptable plan to correct noncompliance items, and is made pursuant to 62 P.S. § 1026 (b)(1);(5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation).

In accordance with 55 Pa. Code § 2600.269 (b) (relating to ban on admissions), no new resident admissions are permitted after the date of this letter.

If you disagree with the decision to REFUSE to RENEW your 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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you

decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED] Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
[REDACTED]

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.

The enclosed violation report specifies plans of correction and dates by which corrections must be made. If you choose to appeal, an acceptable plan of correction must be followed during your operation pending your appeal. Sterling Home is required to remain in full compliance with all applicable statutes and regulations, including but not limited to Article X of the Human Services Code, 62 P.S. §§ 1001 et seq., and 55 Pa. Code Ch. 2600 (relating to Personal Care Homes).

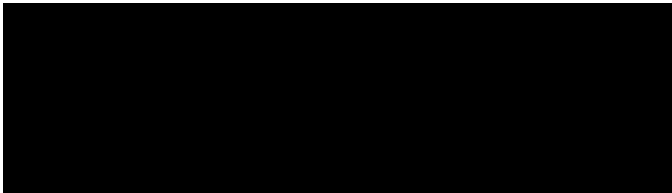
Sincerely,



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: *STERLING HOME* License #: *45269* License Expiration: *12/04/2025*
Address: *1318 ARCH STREET, MCKEESPORT, PA 15132*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *STERLING HOME LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: Total Daily Staff: *40* Waking Staff: *30*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Incident* Exit Conference Date: *06/24/2025*

Inspection Dates and Department Representative

06/24/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42* Residents Served: *39*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *36* Are 60 Years of Age or Older: *32*
Diagnosed with Mental Illness: *24* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *1* Have Physical Disability: *1*

Inspections / Reviews

06/24/2025 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/16/2025*

Inspections / Reviews (*continued*)

07/22/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/16/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 07/28/2025

07/29/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/28/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 08/30/2025

12/19/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/05/2025

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

42b - Abuse

1. Requirements

2600.

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

Description of Violation

On [REDACTED] resident #1 used both hands to forcibly push resident #2 in the hallway. Resident #2 fell backwards, causing resident #2 to hit [REDACTED] head off the ground. Resident #2 was sent to the hospital for evaluation and treatment.

REPEAT VIOLATION: 8/12/2024

Plan of Correction

Directed [REDACTED] 07/29/2025

Immediately following the incident on [REDACTED] the Executive Director implemented a supervision plan for resident #1 to ensure the safety of all other residents while an appropriate long-term solution was determined. Upon resident #2's return from the hospital, the community instituted a temporary separation plan between resident #1 and resident #2 to prevent further interaction or potential for reoccurrence. Resident #2 returned to the community with no diagnosed injuries. After evaluating the incident and the needs of resident #1, it was determined that the community could no longer meet resident #1's behavioral and safety needs. The Executive Director, in coordination with the resident's designated representative, initiated and completed the transition to a more appropriate care setting, and resident #1 was successfully discharged on [REDACTED].

To address this incident at the systemic level and to reinforce compliance with § 2600.42(b), the Executive Director conducted a mandatory in-service training on March 25, 2025, for all staff on 03/25/25. The training covered the regulatory requirements prohibiting neglect, abuse, mistreatment, and intimidation of residents, as well as appropriate behavioral response techniques, intervention strategies, and the obligation to report changes in resident behavior promptly. Special emphasis was placed on early recognition of potential behavioral escalation and preventive supervision strategies. Documentation will be kept in accordance regulation.

The Executive Director or designee will be responsible for monitoring ongoing compliance with this regulation. All staff are required to report any observed changes in resident behavior immediately to the Wellness Team or Executive Director so that proactive interventions can be implemented accordingly. By 08/05/25 a behavior tracking log will be implemented into the community and the Executive Director or Designee will review all logs at daily stand-up meetings to determine if interventions, provider referrals, medication reviews or other safe management techniques need to be implemented into the resident(s) care plan. This may include a care conference to be scheduled with family. This behavior tracking will help the community to identify and address any resident behaviors that could contribute to resident-to-resident abuse. Additionally, by 08/15/25 the Executive Director will survey all the residents and staff. The survey will be anonymous to encourage honest transparent feedback to the community. After the completion of the survey the Executive Director will schedule a Quality Meeting by 08/30/25 to address quality improvement initiatives related to 2600.42. (DIRECTED: Documentation of the quality management review shall be kept. [REDACTED] 7/29/25). However, during the course of the survey, if any concerns arise the Executive Director will address immediately upon notification.

Proposed Overall Completion Date: 08/30/2025

42b - Abuse (continued)

Directed Completion Date: 08/30/2025

Not Implemented [REDACTED] - 12/19/2025)

85b - Infestation

2. Requirements

2600.

85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

At approximately 9:30am, 4 dead bed bugs and 2 live bed bugs were observed on resident #3's bed. In addition, 2 live bed bugs were observed crawling on the wall next to resident #3's bed, and approximately 12 dead bedbugs were observed on the floor surrounding resident #3 and #4's beds in shared bedroom [REDACTED]

At approximately 9:45am, 7 live bed bugs were observed on resident #5's bed, and 1 live bed bug was observed on resident #6's bed in shared bedroom [REDACTED]

REPEAT VIOLATION: 3/10/2025

Plan of Correction

Accept [REDACTED] 07/29/2025)

On June 24, 2025, signs of bedbug activity were identified in the rooms of residents #3, #4, #5, #6, and [REDACTED]. The Executive Director and designated staff responded immediately by removing and bagging all bedding and linens from the affected rooms. The rooms were sanitized, and clean linens were placed. Pestco, a licensed pest control provider, was contacted the same day, and extermination services were initiated without delay. Additional staff assisted with preparing resident belongings, laundering clothing and linens offsite, and relocating residents temporarily to ensure their safety and allow for thorough treatment. Extermination services were scheduled to take place while residents were out of the building on a planned outing, minimizing disruption to their daily routine.

To address the issue long term, a full-building extermination was completed by Pestco on July 11, 2025. Pest control monitoring will continue until Pestco confirms the building is clear. As a preventive measure, all mattresses have been fitted with zippered protective covers. On July 3rd, 2025, a Pestco representative conducted a comprehensive training session for all staff, which included education on bedbug identification, containment procedures, and prevention strategies. To further reduce the risk of reintroduction, staff were offered confidential, no-cost home extermination services through Pestco.

The Executive Director is responsible for ensuring ongoing compliance with pest control protocols, including coordination of continued monitoring services, oversight of staff training, and maintenance of all relevant documentation.

As of 07/22/25 the Executive Director or designee will audit 10 residents' rooms and mattresses per day for four weeks to determine if the infestation has subsided. Although daily rounds are implemented as of 07/12/25 to all rooms as part of a broader plan to address the problem the audits will include a more comprehensive search of the selected residents bedding, bed frames and other parts of the residents' room. This will include a thorough check of headboards and sheets. If any evidence of infestation is noted the Executive Director will be responsible to

85b - Infestation (continued)

remediate immediately. The audit records will be kept by the Executive Director.

Licensee's Proposed Overall Completion Date: 08/19/2025

Implemented [REDACTED] 12/19/2025)

101j3 - Bed/Linens/Pillows/Blankets**3. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

At approximately 9:45am, numerous small dark spots, which appeared to be blood, covered the entire top-right side of resident #5's bed sheet.

REPEAT VIOLATION: 12/19/2024; 8/12/2024

Plan of Correction

Accept [REDACTED] 07/29/2025)

On 06/24/25 Immediate corrective action was taken by the Executive Director and designated staff, who removed the soiled sheet, inspected the mattress for any additional concerns, and replaced the linens with fresh, clean bedding.

This matter was addressed as part of a broader corrective plan following a pest concern in the community. All staff received in-service training from a Pestco representative on July 3, 2025. The training included instruction on identifying bedbug activity, recognizing signs of infestation such as blood spots on linens, and maintaining proper bed hygiene. On July 11, 2025, the entire facility was professionally treated by Pestco. During this process, all resident laundry, including bedding and clothing, was bagged, washed, dried, and returned to residents. New pillows and sheets were purchased and placed on each bed, and all blankets were laundered and returned to the facility.

To prevent recurrence, as of 07/12/25 the Administrator or Wellness Coordinator will conduct daily rounds to ensure that every resident bed is made with clean, intact linens including pillows, sheets, and blankets. These inspections will be documented and integrated into the community's annual quality plan. Staff have been instructed to report any soiled or damaged linens immediately and replace them without delay.

The Executive Director will be responsible for ongoing compliance with 55 Pa. Code § 2600.101(j)(3), ensuring proper linen standards are maintained and that staff remain vigilant in reporting and correcting any deficiencies.

Licensee's Proposed Overall Completion Date: 07/28/2025

Not Implemented [REDACTED] 12/19/2025)

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

Facility Information

Name: *STERLING HOME* License #: *45269* License Expiration: *12/04/2025*
Address: *1318 ARCH STREET, MCKEESPORT, PA 15132*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *STERLING HOME LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *01/30/2003* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *42* Waking Staff: *32*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint, Provisional, Incident* Exit Conference Date: *09/08/2025*

Inspection Dates and Department Representative

08/20/2025 - On-Site: [REDACTED]
08/25/2025 - On-Site: [REDACTED]
09/03/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42* Residents Served: *41*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *38* Are 60 Years of Age or Older: *36*
Diagnosed with Mental Illness: *41* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *1* Have Physical Disability: *1*

Inspections / Reviews

08/20/2025 - Full

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

09/19/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *09/18/2025*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/25/2025*

09/26/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *09/25/2025*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *10/28/2025*

12/19/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: *10/28/2025*
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

15a - Resident Abuse Report**1. Requirements**

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 8/7/25 at approximately 2:30pm, direct care staff person A received an allegation of financial abuse against [REDACTED] the home's administrator; however, this allegation of financial abuse was not reported to the local Area Agency on Aging until 8/8/25 at approximately 6:00pm.

Plan of Correction**Accept [REDACTED] 09/19/2025)**

On August 8, 2025, at approximately 11:30 a.m., the Regional Director was notified by Employee A of an allegation of financial abuse. Upon receiving the report, the Regional Director immediately suspended the Administrator and began investigating the matter. In addition, [REDACTED] was required to develop a plan to ensure the community remained in compliance with the regulatory requirement of having an acting Administrator in place, which demanded immediate attention.

At the time of the initial report, no specific victims were identified. Because the Older Adult Protective Services Act requires that a report include the name(s) of the individual(s) alleged to have been abused, the broad nature of the allegation prevented the Regional Director from submitting a complete report to Protective Services within the initial 24-hour timeframe. During the early stages of the investigation, the Administrator denied all allegations, stating that the complaint originated from [REDACTED] and was retaliatory in nature.

Later that same day, after interviewing residents and staff, the Regional Director re-contacted the Administrator to ask additional clarifying questions. During this follow-up conversation, the Administrator admitted that [REDACTED] had assisted certain residents and provided the Regional Director with the names of those residents. Once the alleged victims were identified, the Regional Director was able to make a complete report to the Area Agency on Aging.

The delay in reporting was therefore the result of the need to establish the identities of the potential victims, which is a required element under the Older Adult Protective Services Act, combined with the Regional Director's immediate responsibilities to secure leadership coverage for the community while simultaneously conducting the investigation. On 08/25/25 the Regional Director Completed a Root Cause Analysis which resulted in a policy revision that is in line with the Older Adult Protective Services Act to address any systemic issues.

The late submission occurred because the Regional Director did not have the names of alleged victims at the time of the initial allegation, which are required elements for a valid Protective Services report. Additionally, the Regional Director was simultaneously managing urgent regulatory obligations to ensure uninterrupted community leadership coverage after suspending the Administrator, which diverted attention from the reporting process.

Therefore, as of 09/01/25 a policy revision was put into effect and will be presented to all staff at all teams meeting scheduled on 09/19/25.

Policy Revision – The community's abuse reporting protocol will be updated to clarify that all allegations, even if initially incomplete or lacking specific victims, must be reported orally immediately to Protective Services upon notification, with supplemental details provided as they are confirmed. The persons reporting will be required to

15a - Resident Abuse Report (continued)

document the time and name of protective services person they spoke with and will need to complete a form contact the Administrator, Executive Director and Owner immediately with the allegation and other available details.

Training – All Regional Directors, Executive Directors/Administrators will receive refresher training on the requirements of the Older Adult Protective Services Act, with emphasis on the 24-hour reporting mandate and the process for filing reports when information is incomplete by 09/19/25.

Oversight Process – A compliance checklist will be added to incident investigations, requiring documentation of Protective Services notification within 24 hours. The checklist will be reviewed by the Regional Director and retained in the investigation file.

Licensee's Proposed Overall Completion Date: 09/19/2025

Implemented () - 12/19/2025)

16c - Written Incident Report**2. Requirements**

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 8/7/25 at approximately 2:30pm, direct care staff person A received an allegation of financial abuse against [REDACTED] the home's administrator; however, this allegation of financial abuse was not reported to the Department until 8/8/25 at approximately 6:00pm.

Plan of Correction

Directed () 09/26/2025)

On August 8, 2025, at approximately 11:30 a.m., the Regional Director was notified by Employee A of an allegation of financial abuse. Upon receiving the report, the Regional Director immediately suspended the Administrator and began investigating the matter. In addition, [REDACTED] was required to develop a plan to ensure the community remained in compliance with the regulatory requirement of having an acting Administrator in place, which demanded immediate attention.

At the time of the initial report, no specific victims were identified. Because the Older Adult Protective Services Act requires that a report include the name(s) of the individual(s) alleged to have been abused, the broad nature of the allegation prevented the Regional Director from submitting a complete report to Protective Services within the initial 24-hour timeframe. During the early stages of the investigation, the Administrator denied all allegations, stating that the complaint originated from [REDACTED] and was retaliatory in nature.

Later that same day, after interviewing residents and staff, the Regional Director re-contacted the Administrator to ask additional clarifying questions. During this follow-up conversation, the Administrator admitted that [REDACTED] had assisted certain residents and provided the Regional Director with the names of those residents. Once the alleged victims were identified, the Regional Director was able to make a complete report to the Area Agency on Aging.

16c - Written Incident Report (continued)

The delay in reporting was therefore the result of the need to establish the identities of the potential victims, which is a required element under the Older Adult Protective Services Act and under DHS 2600.16c regulatory guidelines combined with the Regional Director's immediate responsibilities to secure leadership coverage for the community while simultaneously conducting the investigation. On 08/25/25 the Regional Director Completed a Root Cause Analysis which resulted in a policy revision that is in line with the Older Adult Protective Services Act to address any systemic issues and reporting to DHS.

The late submission occurred because the Regional Director did not have the names of alleged victims at the time of the initial allegation, which are required elements for a valid Protective Services report. Additionally, the Regional Director was simultaneously managing urgent regulatory obligations to ensure uninterrupted community leadership coverage after suspending the Administrator, which diverted attention from the reporting process.

Therefore, as of 09/01/25 a policy revision was put into effect and will be presented to all staff at all teams meeting scheduled on 09/19/25.

Policy Revision – The community's abuse reporting protocol will be updated to clarify that all allegations, even if initially incomplete or lacking specific victims, must be reported orally immediately to Protective Services upon notification, with supplemental details provided as they are confirmed. The persons reporting will be required to document the time and name of protective services person they spoke with and will need to complete a form contact the Administrator, Executive Director and Owner immediately with the allegation and other available details.

Training – All Regional Directors, Executive Directors/Administrators will receive refresher training on the requirements of the Older Adult Protective Services Act and 2600.16c guidelines, with emphasis on the 24-hour reporting mandate and the process for filing reports when information is incomplete by 09/19/25.

Oversight Process – A compliance checklist will be added to incident investigations, requiring at minimum an initial report to DHS within 24 hours as well as to adhering to the OAPS guidelines. The checklist will serve as a compliance safeguard to ensure all incidents specified under 55 Pa. Code § 2600.16(a) are reported to the Department within 24 hours. The form prompts staff to document the type of incident, time of occurrence, time of Administrator notification, and time of Department submission. The Administrator or designee will review each checklist to verify timely reporting, and completed checklists will be email scanned to the Executive Director and Regional Director daily for oversight. This process establishes accountability, provides oversight, and ensures compliance with the 24-hour reporting requirement. (DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator/designee shall review the checklists daily to ensure all reportable incidents specified in 2600.16a are reported to the Department within 24 hours in accordance with 2600.16c. [REDACTED] 9/26/25)

Proposed Overall Completion Date: 09/24/2025

Directed Completion Date: 09/27/2025

Implemented [REDACTED] 12/19/2025)

18 - Compliance With Laws**3. 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

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16, requires the date of battery installation to be present on the battery of all battery-operated carbon monoxide detectors and that the batteries must be

18 - Compliance With Laws (continued)

replaced at least once annually. However, the date of battery installation indicated on the carbon monoxide detector on the ceiling of the television room in Hallway A indicates the battery was replaced on 7/29/22.

REPEAT VIOLATION: 12/19/2024

Plan of Correction

Accept [REDACTED] 09/26/2025)

On 08/20/25 the Maintenance Director changed the batteries on this carbon monoxide detector and also labelled the date of the battery installation. The community has more than one carbon monoxide the detector and the new Maintenance Coordinator did not realize [REDACTED] had missed this one as part of [REDACTED] routine checks. As of 09/19/25 there will be a new procedure requires the maintenance coordinator to check the all the carbon monoxide detectors monthly to ensure compliance. As of 09/18/25 all staff will be educated by the Executive Director designee on The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16 and 2600.18 to ensure ongoing compliance.

Proposed Overall Completion Date: 09/24/2025

Licensee's Proposed Overall Completion Date: 09/24/2025

Not Implemented (LM - 12/19/2025)

23b - Instrumental Activities of Daily Living Assistance

4. Requirements

2600.

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

Description of Violation

Resident #5 currently receives dialysis treatments on Tuesdays, Thursdays and Saturdays; however, resident #5 did not receive [REDACTED] dialysis treatments on 8/16/25, 8/21/25 or on 8/26/25. Resident #5's most recent assessment, dated 6/10/25, indicates resident #5 requires some physical assistance with making and keeping appointments and securing and using transportation.

Plan of Correction

Directed [REDACTED] 09/26/2025)

On 08/30/25 the care plan was updated and all staff that works the shift during the time [REDACTED] needs to board the bus was educated by the Administrator Designee of the resident's care plan needs and all Direct Care staff will be retrained on 09/19/25 on 2600.3b. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 9/26/25). As of 09/18/25 a reminder task has been entered into the resident's Medication Administration Record (MAR) to ensure staff provide verbal prompts to Resident #5 prior to dialysis transportation days (Tuesdays, Thursdays, Saturdays). This will entail staff will provide direct reminders and confirmation that Resident #5 is awake and prepared to meet the bus at the designated time.

On 09/19/25 all Direct Care Staff have been retrained on the importance of reviewing support plans and providing required assistance with IADLs, including transportation and appointment reminders. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 9/26/25). A record of this training will e kept in the Executive Directors office in accordance with 2600.65a.

This process will be reviewed at the next scheduled quality review meeting, which is scheduled to be held on October 28, 2025, that will include all items specified in 2600.26b, to ensure ongoing compliance. Monitoring Steps as of

23b - Instrumental Activities of Daily Living Assistance (continued)

09/18/25 include: (DIRECTED: Documentation of the quality management review shall be kept. [REDACTED] 9/26/25).

The direct care staff assigned to Resident #5's care will initial the MAR reminder task each dialysis day (Tuesday, Thursday, Saturday) to confirm that verbal prompts were provided and that the resident was awake, prepared, and escorted to meet the transportation provider.

The shift lead will confirm the resident's departure and will document the resident's departure for dialysis and [REDACTED] return in the daily communication log. If the resident refuses care for any reason the shift lead will be responsible to immediately call the Administrator for assistance.

The Administrator or Director of Wellness be responsible to confirm every Tuesday, Thursday and Saturday morning with the staff to ensure the resident went to Dialysis.

Proposed Overall Completion Date: 09/25/2025

Directed Completion Date: 10/28/2025

Not Implemented ([REDACTED] 12/19/2025)

42b - Abuse**5. Requirements**

2600.

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

Description of Violation

On or around 11/24/24, the representative payee for residents #1 and #2 mailed TrueLink debit cards for each resident to the home. [REDACTED] the home's administrator, is the only person who had access to the debit cards upon receipt. However, between 11/21/24 through 7/6/25, resident #1's debit card was used to withdraw approximately \$627.75 in cash and banking fees from numerous automated teller machines (ATM's) near the home, as well as used to make numerous online Walmart purchases totaling approximately \$197.48. Also, between 11/21/24 through 6/21/25, resident #2's debit card was used to withdraw approximately \$1,313.20 in cash and banking fees from numerous ATM's near the home, as well as used to make numerous online purchases, including an online Walmart purchase on 12/1/24 totaling \$198.29, and an in-store Kohl's purchase on 12/22/24 totaling \$55.15. Both residents #1 and #2 indicated they were unaware that debit cards were mailed to the home and neither resident have ever used the debit card to make purchases or cash withdrawals. Also, both residents #1 and #2 indicated they never requested or received any cash or purchases from [REDACTED]

Plan of Correction

Directed [REDACTED] 09/26/2025)

On 08/23/25 upon notification from Department of the transaction history and information obtained to substantiate financial abuse the administrator was released from [REDACTED] duties by the home. On 08/23/25 the Regional Director contacted the rep payee for the copy of the McKeesport transaction history. On 08/23/25 the Regional

42b - Abuse (continued)

Director reported this to the McKeesport Police department was informed that either the resident or representative with access to the resident's accounts will need to come in person and complete fraud packets and return to the police department in person as this is the process for this type of complaint. The packets require account information the home does not have access to. The regional Director contacted the rep payee, and they suggested the cards be terminated and they will issue new cards to the residents. The Administrator designee contacted the residents responsible party to inform them of this process so they can follow up on any action on the resident's behalf. As of 08/08/25 upon notification of the abuse allegation the Regional Director created a financial management book that that will track, and log transactions of any funds managed by the community on behalf any residents. on 08/25/25 the current administrator was informed of this violation and educated on this regulation. On 09/19/25 the Administrator will train all staff on 2600.42b at all teams meeting. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 9/26/25). The police requested that the resident or resident's responsible parties come in person with bank account information and complete fraud packets. The regional Director offered the transaction report and was told that the packet must be completed by the alleged victim or guardian. The Regional Director informed the rep payee as the community does not have access to more than just the transaction report that was provided. The police did not make contact resident's number 1 and 2. As of [REDACTED] the community has a new permanent Administrator. The cards had not yet been issued as of yet. Therefore, this Administrator contacted RPS, the rep payee and requested that no new cards are issued and that the rep payee issues rent checks and allowance checks moving forward. The new administrator will be responsible at this time to oversee any financial management process temporarily until a 30-day notice can be issued to any residents requiring financial assistance. The 30-day notice will be issued to all residents and their responsible parties by 09/30/25 informing all residents of the upcoming policy change that the home will no longer assist with the management of any resident financials. (DIRECTED: By 9/30/25: Documentation of notification to the residents regarding the home's changes to financial management shall be kept in each resident's record. [REDACTED] 9/26/25). Until the new policy takes effect and if applicable any residents requiring assistance will have a transaction log kept in the financial book that will include all items specified in 2600.20b (1).

DIRECTED: By 9/30/25: The administrator/designee shall update the home's description of services and resident-home contract to indicate the home no longer will be providing financial management to residents. The updated resident-home contract shall be used for all new admissions. [REDACTED] 9/26/25

Proposed Overall Completion Date: 09/30/2025

Directed Completion Date: 09/30/2025

Not Implemented [REDACTED] 12/19/2025)

57d - Waking Hours**6. Requirements**

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 8/16/25, there were 40 residents residing in the home, including 1 resident with a mobility need, requiring a total minimum of 30.75 hours of direct care staffing during waking hours. However, on 8/16/25, only 22.5 hours of direct care staffing were provided during waking hours.

57d - Waking Hours (continued)

On 8/17/25, there were 40 residents residing in the home, including 1 resident with a mobility need, requiring a total minimum of 30.75 hours of direct care staffing during waking hours. However, on 8/17/25, only 28 hours of direct care staffing were provided during waking hours.

REPEAT VIOLATION: 12/19/2024

Plan of Correction

Accept [REDACTED] 09/26/2025)

On 08/20/25 the Regional Director counselled the Executive Director and designee on 2600.57d to ensure understanding and compliance of this regulation. Documentation of this counselling will be kept in the Executive Directors office. On 8/23/25 the Executive Director no longer worked for the community. On 08/25/25 the Regional Director reviewed this violation with the acting Administrator to ensure understanding of this deficiency and to ensure that this deficiency is not repeated. As of 09/01/25 the Wellness Assistant is now required to provide the administrator a copy of the following two weeks of schedules in advance and the Administrator will be required to check schedule to ensure adequate staffing that meets 2600.57d. Additionally, a new policy and procedure is in effect as of 09/01/25 that will require the Administrator or Designee to be responsible to secure coverage if scheduled staff call off or if there are any other coverage shortages. This policy and procedure outline the steps and resources available. The Regional Director reviewed this Policy and Procedure with the acting Administrator and Designee on 09/01/25. As of 09/24/25 the Administrator will be responsible to review shall review direct care staffing daily to ensure compliance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a weekly for the upcoming week and daily as needed to account for variances such as unexpected call offs.

Licensee's Proposed Overall Completion Date: 09/24/2025

Implemented ([REDACTED] 12/19/2025)

65a - FS Orientation 1st Day**7. Requirements**

2600.

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

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

Description of Violation

Direct care staff person D, hired on [REDACTED] did not receive orientation on any of the topics specified in 2600.65a.

Plan of Correction

Accept [REDACTED] 09/26/2025)

On 08/21/25 direct care staff person D completed First Day Orientation topics with the Administrator Designee and Maintenance Coordinator that included all the topics under 2600.65.a. Documentation of this training was

65a - FS Orientation 1st Day (continued)

obtained and will be kept in the Executive Directors office with the training records. On 09/01/25 all employee training records were audited to ensure compliance with 2600.65.a. All training records meet the 2600.65a. guidelines are kept in the Administrators office. On 08/21/25 the administrator was counselled by the Regional Director on this regulation. On [REDACTED] the administrator no longer was employed but the community. As of 08/25/25 the acting administrator was informed of this violation by the regional Director and understands the regulation and will be responsible to ensure ongoing compliance. As of 09/24/25 a new hire checklist will be in effect to ensure all new hires receive orientation timely and in accordance with 2600.65a.

Licensee's Proposed Overall Completion Date: 09/24/2025

Implemented [REDACTED] 12/19/2025)

65b - Rights/Abuse 40 Hours**8. Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

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

Description of Violation

Direct care staff person D, hired on [REDACTED] did not receive orientation on any of the topics specified in 2600.65b.

Plan of Correction

Accept [REDACTED] 09/26/2025)

On 08/21/25 direct care staff person D completed First Day Orientation topics with the Administrator Designee and Maintenance Coordinator as well as residents' rights, emergency medical plan, mandatory abuse reporting and neglect under the Older Adult Protective Services Act and included all the topics under 2600.65.b. Documentation of this training was obtained and will be kept in the Administrators office with the employee training records. On 09/01/25 all employee training records were audited to ensure compliance with 2600.65.b. All training records meet the 2600.65b. guidelines are kept in the Administrators office. On 08/21/25 the administrator was counselled by the Regional Director on this regulation. On [REDACTED] the administrator no longer was employed but the community. As of 08/25/25 the acting administrator was informed of this violation by the regional Director and understands the regulation and will be responsible to ensure ongoing compliance. On 09/19/25 all staff will be notified of this regulation at the all-staff meeting. As of 09/24/25 a new hire checklist will be implemented at sterling home to ensure no steps are missed in the hiring process as it relates to training or any other staff hiring requirements.

Licensee's Proposed Overall Completion Date: 09/24/2025

Implemented [REDACTED] 12/19/2025)

65f - Training Topics**9. Requirements**

2600.

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

65f - Training Topics (*continued*)

3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A, hired on [REDACTED] did not receive training on any of the topics specified in 2600.65f during the 2024 training year.

Plan of Correction

Directed [REDACTED] 09/26/2025)

By 09/25/25 staff person A completed all the required annual training for 2600.65f. Documentation of this training will be kept. By 09/25/25 the Administrator will complete an audit of all staff training to ensure that all staff have met the training requirements as per 2600.65f. Moving forward all staff will be assigned to take one training course a month as scheduled by the administrator to meet regulation 2600.65f. This training may be online via the Learning Management system or in person at a scheduled monthly training. On 08/25/25 the acting administrator was informed of this regulation and violation report, and the Administrator will be responsible to ensure ongoing compliance. The Administrator will track each employee's monthly progress of annual training as specified under 2600 and will send out a notification to staff quarterly for the first and second quarter of each training year of their progress and monthly for the third quarter and weekly for the fourth quarter. (DIRECTED: The administrator's monthly reviews of all staff person trainings shall begin on 10/1/25 to ensure compliance with 2600.65f. [REDACTED] 9/26/25). The training progress will also be reviewed at the Quarterly Quality Plan Meeting as per 2600.26b. Any staff identified as nearing the end of the training year that has not completed training will be removed from the employee roster two weeks before the end of the training year until completion. The Executive Director will then be required to ensure full completion within that time period. Failure to complete the training by the last day of the training year will result in termination of the employee. The Executive Director will be

Proposed Overall Completion Date: 09/25/2025

Directed Completion Date: 10/01/2025

Implemented [REDACTED] 12/19/2025)

65g - Annual Training Content

10. Requirements

- 2600.
- 65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
 3. Resident rights.
 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
 5. Falls and accident prevention.

Description of Violation

Direct care staff person A, hired on [REDACTED] did not receive training on on the following topics during the 2024 training year:

- Emergency preparedness procedures and recognition and response to crises and emergency situations
- Resident rights

65g - Annual Training Content (continued)

- The Older Adult Protective Services Act
- Falls and accident prevention

Ancillary staff person C, hired on [REDACTED] did not receive training on on the following topics during the 2024 training year:

- Emergency preparedness procedures and recognition and response to crises and emergency situations
- Resident rights
- The Older Adult Protective Services Act
- Falls and accident prevention

Plan of Correction**Directed [REDACTED] - 09/26/2025)**

On 08/25/25 Staff persons A and C received training on all the topics under 2600.65g. The documentation for staff persons A and C will be kept. By 09/25/25 the Administrator will complete an audit of all staff training to ensure that all staff have met the training requirements as per 2600.65f. Moving forward all staff will be assigned to take one training course a month as scheduled by the administrator to meet regulation 2600.65f. This training may be online via the Learning Management system or in person at a scheduled monthly training. On 08/25/25 the acting administrator was informed of this regulation and violation report, and the Administrator will be responsible to ensure ongoing compliance. The home's long term monitoring steps to ensure all staff receive training on all topics as specified in 2600.65 will for the Administrator to maintain a monthly tracking of each employees hire date and subsequently to schedule employees the month prior to their anniversary date to complete [REDACTED] annual training of the topics listed under 2600.65g. (DIRECTED: The administrator's monthly reviews of all staff person trainings shall begin on 10/1/25 to ensure compliance with 2600.65g. [REDACTED] 9/26/25).

Proposed Overall Completion Date: 09/25/2025

Directed Completion Date: 10/01/2025

Implemented [REDACTED] - 12/19/2025)**85a - Sanitary Conditions****11. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8/20/25 at approximately 10:00am, approximately 12 dead bed bugs were present on the floor next to residents #3 and #4's beds in bedroom [REDACTED]

Plan of Correction**Accept [REDACTED] - 09/26/2025)**

On 08/20/25 following inspection room [REDACTED] was cleaned by a member of the housekeeping team to include changing of bedding and vacuuming of dead bedbugs that were a residual from a recent treatment that was done by Pestco to address an infestation. On [REDACTED] the Regional Director Counseled the Executive Director regarding

85a - Sanitary Conditions (continued)

this violation as well as others. As of [REDACTED] the Executive Director was no longer employed by the home. On 08/25/25 The acting administrator was educated, by the Regional Director on this violation and the entire inspection outcome preliminary report in order to address all violations. The current administrator is developed a new housekeeping schedule cleaning protocol for the housekeeping team that is more thorough and addresses the sanitation violation. On 09/19/25 an all-staff meeting is scheduled, and all staff will be educated on this regulation and their responsibilities to report. A record of this training will be kept in the Executive Directors Office and will be kept with employee training records in accordance of 2600.65. The following will be the weekly housekeeping Room Assignment Breakdown for two housekeepers and will be fully implemented by 10/01/25 after a meeting with the housekeepers to review the assignments and cleaning protocols.

Monday (Housekeeper B only)

Rooms 1–4 (regular cleaning).

Bathrooms 1–5 (all shifts).

Dining room after each meal.

Hallways, offices, smoking areas.

Tuesday (A & B)

Housekeeper A: Rooms 5–8.

Housekeeper B: Rooms 9–11.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal, hallways, smoking areas.

Deep Clean: Room 1.

Wednesday (A & B)

Housekeeper A: Rooms 12–14.

Housekeeper B: Rooms 15–16.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal, hallways, smoking areas.

Dining Room Deep Clean (walls, chairs, vents, etc).

Thursday (A & B)

Housekeeper A: Rooms 17–19.

Housekeeper B: Rooms 20–22.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal, hallways, smoking areas.

Deep Clean: Room 2.

Friday (Housekeeper A only)

Rooms 1–4 (light touch-up/spot clean if needed).

Bathrooms 1–5.

Dining room after each meal.

Hallways, offices, smoking areas.

Office Deep Clean (Executive Director & Wellness).

Saturday (Housekeeper A only)

Rooms 5–11 (rotation support).

Bathrooms 1–5.

Dining after each meal.

Hallways, smoking areas.

Sunday (A & B)

Housekeeper A: Rooms 12–16.

85a - Sanitary Conditions (continued)

Housekeeper B: Rooms 17–22.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal.

Hallways, smoking areas.

Deep Cleaning Rotation

Tuesday: First deep clean of week (starts at Room 1, moves upward each week).

Thursday: Second deep clean of week (next room in sequence).

Rotation continues until all 22 rooms are completed, then repeats.

To ensure long term monitoring and compliance the housekeeping team will be required to sign off on the daily assignment sheet and turn in the assignment to the Administrator or designee for review. The administrator will check the rooms against the assignment sheets daily for one week and then weekly thereafter to ensure ongoing compliance to ensure proper cleaning protocols are being adhered to. Pestco is scheduled to return to the home 09/26/25.

Licensee's Proposed Overall Completion Date: 09/26/2025

Implemented [REDACTED] 12/19/2025)

94b - Non-Skid Surface**12. Requirements**

2600.

94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

On 8/20/25, no nonskid surface was present on the exterior stairs leading outside from Hallway A to the rear patio.

Plan of Correction

Accept [REDACTED] 09/26/2025)

On 08/20/25 the Maintenance Coordinator added non-skid tiles to the exterior stairs leading outside hallway A to ensure a nonskid surface. There are no other stairs in or around the building which is a one-story structure. On 08/20/25 the Maintenance Coordinator was educated on the 2600.94b by the Regional Director and acknowledged understanding that [REDACTED] is responsible to maintain the non-skid surfaces throughout the interior and exterior of the building and will now conduct a weekly walkthrough to ensure ongoing compliance. Weekly walkthroughs began on 08/25/25.

Licensee's Proposed Overall Completion Date: 09/24/2025

Implemented [REDACTED] 12/19/2025)

101j3 - Bed/Linens/Pillows/Blankets**13. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 8/20/25 at approximately 10:00am, no pillowcase was present on resident #3's pillow. Also, numerous red and brown stains were present on resident #3's pillow and resident #3's top bed sheet. Additionally, no fitted sheet was present on resident #3's bed.

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

REPEAT VIOLATION: 12/19/2024

Plan of Correction

Accept [REDACTED] 09/26/2025)

On 08/20/25 following inspection resident #3's housekeeping team to include changing of bedding a to include replacement of clean sheets and pillowcases. The bed was made with both a fitted and top sheet. On [REDACTED] the Regional Director Counseled the Executive Director regarding this violation as well as others. As of [REDACTED] the Executive Director was no longer employed by the home. On [REDACTED] The acting administrator was educated, by the Regional Director on this violation and the entire inspection outcome preliminary report in order to address all violations. The current administrator is developed a new housekeeping schedule cleaning protocol for the housekeeping team that is more thorough and addresses the sanitation violation and regulation 2600.101j3. On 09/19/25 an all-staff meeting is scheduled, and all staff will be educated on this regulation and their responsibilities to report. A record of this training will be kept in the Executive Directors Office and will be kept with employee training records in accordance of 2600.65. The following will be the weekly housekeeping Room Assignment Breakdown for two housekeepers and will be fully implemented by 10/01/25 after a meeting with the housekeepers to review the assignments and cleaning protocols.

Monday (Housekeeper B only)

Rooms 1–4 (regular cleaning).

Bathrooms 1–5 (all shifts).

Dining room after each meal.

Hallways, offices, smoking areas.

Tuesday (A & B)

Housekeeper A: Rooms 5–8.

Housekeeper B: Rooms 9–11.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal, hallways, smoking areas.

Deep Clean: Room 1.

Wednesday (A & B)

Housekeeper A: Rooms 12–14.

Housekeeper B: Rooms 15–16.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal, hallways, smoking areas.

Dining Room Deep Clean (walls, chairs, vents, etc).

Thursday (A & B)

Housekeeper A: Rooms 17–19.

Housekeeper B: Rooms 20–22.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal, hallways, smoking areas.

Deep Clean: Room 2.

Friday (Housekeeper A only)

Rooms 1–4 (light touch-up/spot clean if needed).

Bathrooms 1–5.

Dining room after each meal.

Hallways, offices, smoking areas.

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

Office Deep Clean (Executive Director & Wellness).

Saturday (Housekeeper A only)

Rooms 5–11 (rotation support).

Bathrooms 1–5.

Dining after each meal.

Hallways, smoking areas.

Sunday (A & B)

Housekeeper A: Rooms 12–16.

Housekeeper B: Rooms 17–22.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal.

Hallways, smoking areas.

Deep Cleaning Rotation

Tuesday: First deep clean of week (starts at Room 1, moves upward each week).

Thursday: Second deep clean of week (next room in sequence).

Rotation continues until all 22 rooms are completed, then repeats.

To ensure long term monitoring and compliance the housekeeping team will be required to sign off on the daily assignment sheet and turn in the assignment to the Administrator or designee for review. The administrator will check the rooms against the assignment sheets daily for one week and then weekly thereafter to ensure ongoing compliance to ensure proper cleaning protocols are being adhered to.

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

Not Implemented [REDACTED] 12/19/2025)

101o - Walls, Floors, Ceilings**14. Requirements**

2600.

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

Description of Violation

On 8/20/25 at approximately 10:00am, numerous dark brown/black spots, which appear to be mold, were present throughout bedroom [REDACTED] where residents #3 and #4 currently reside. The spots are present on the walls and ceiling throughout the bedroom.

Plan of Correction

Accept ([REDACTED] 09/26/2025)

On [REDACTED] following the inspection room [REDACTED] walls were cleaned by the housekeeping team to remove spots on walls. On [REDACTED] the Executive Director was counselled by the Regional Director. On [REDACTED] the Executive Director no longer worked for the home. [REDACTED] the Regional Director reviewed with the Acting Executive Director 2600.101.0 and the entire License Inspection Summary in order to ensure understanding of the Administrators Responsibilities to complete daily rounding and room checks to ensure all resident and nonresident areas are in good repair and clean. The current administrator has developed a new housekeeping schedule cleaning protocol for the housekeeping team that is more robust and addresses the sanitation violation. On 09/19/25 an all-staff meeting is scheduled, and all staff will be educated on this regulation and their responsibilities to report. A record of this training will be kept in the Executive Directors Office and will be kept with employee training records

101o - Walls, Floors, Ceilings (continued)

in accordance of 2600.65. By 09/30/25 room [REDACTED] will be fully painted by the Maintenance Coordinator. The following will be the weekly housekeeping Room Assignment Breakdown for two housekeepers and will be fully implemented by 10/01/25 after a meeting with the housekeepers to review the assignments and cleaning protocols.

Monday (Housekeeper B only)

Rooms 1–4 (regular cleaning).

Bathrooms 1–5 (all shifts).

Dining room after each meal.

Hallways, offices, smoking areas.

Tuesday (A & B)

Housekeeper A: Rooms 5–8.

Housekeeper B: Rooms 9–11.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal, hallways, smoking areas.

Deep Clean: Room 1.

Wednesday (A & B)

Housekeeper A: Rooms 12–14.

Housekeeper B: Rooms 15–16.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal, hallways, smoking areas.

Dining Room Deep Clean (walls, chairs, vents, etc).

Thursday (A & B)

Housekeeper A: Rooms 17–19.

Housekeeper B: Rooms 20–22.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal, hallways, smoking areas.

Deep Clean: Room 2.

Friday (Housekeeper A only)

Rooms 1–4 (light touch-up/spot clean if needed).

Bathrooms 1–5.

Dining room after each meal.

Hallways, offices, smoking areas.

Office Deep Clean (Executive Director & Wellness).

Saturday (Housekeeper A only)

Rooms 5–11 (rotation support).

Bathrooms 1–5.

Dining after each meal.

Hallways, smoking areas.

Sunday (A & B)

Housekeeper A: Rooms 12–16.

Housekeeper B: Rooms 17–22.

Bathrooms split (A: 1–3, B: 4–5).

Dining after each meal.

Hallways, smoking areas.

Deep Cleaning Rotation

Tuesday: First deep clean of week (starts at Room 1, moves upward each week).

101o - Walls, Floors, Ceilings (continued)

Thursday: Second deep clean of week (next room in sequence).

Rotation continues until all 22 rooms are completed, then repeats.

To ensure long term monitoring and compliance the housekeeping team will be required to sign off on the daily assignment sheet and turn in the assignment to the Administrator or designee for review. As of 10/01/25 The administrator will check the rooms against the assignment sheets daily for one week and then weekly thereafter to ensure ongoing compliance to ensure proper cleaning protocols are being adhered to. If anything is missed on the assignment or not thoroughly completed the Administrator will meet with the team to determine the root cause of any deficiencies. If additional resources are needed the Administrator will be responsible to provide appropriate additional resources such as additional training on cleaning protocols, managing the schedule, products and tools needed and will evaluate the schedule to ensure the team is able to meet the cleaning demand. If needed the administrator will make changes to the schedule and resources to ensure the success of the housekeeping team. Lastly, if any areas of deficiency are resulting from staff negligence the administrator will be responsible to apply progressive disciplinary action in accordance with the company policy and will seek to make changes in staffing to ensure compliance. This thorough approach places an emphasis on the building sanitation.

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

Not Implemented [REDACTED] **12/19/2025)**

103g - Storing Food**15. Requirements**

2600.

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

Description of Violation

On 8/20/25 at approximately 10:00am, the following open and unsealed food items were present in the stand-up freezer, located in the dry good storage room:

- A bag containing approximately 36 frozen meat patties*
- A bag containing approximately 20 frozen meat patties*

REPEAT VIOLATION: 12/19/2024

Plan of Correction

Directed [REDACTED] **09/26/2025)**

On 08/20/25 the two bags with frozen meat patties were disposed of by the Executive Director. By 09/19/25 at the all-staff meeting/training the Executive Director will review 2600.103 .g. with all the dining staff to ensure understanding of safe food handling and to ensure compliance. Documentation of the education will be kept in the Administrators office. As of 09/14/25 the Acting Administrator or Designee will audit all food storage areas daily for four weeks to ensure compliance by the dining department. (DIRECTED: Immediately following the daily checks, the administrator/designee shall inspect all food storage areas weekly to ensure compliance with 2600.103g. [REDACTED] 9/26/25). The documentation of this will be kept in the Executive Directors office and will be sent to the department by 10/13/25. As part of the homes long-term monitoring steps the Home will review any concerns in next scheduled quality plan meeting that will now be held quarterly and will be next scheduled for 10/28/25. Moving forward the Quality meeting will include the Regional Director and the sister community Executive Director or designee. Notes on the quarterly quality review meeting will be held in the Administrators office, and if any areas of deficiency are identified the Administrator will be responsible to correct immediately and maintain documentation of any

103g - Storing Food (continued)

corrections. Additionally, immediately following weekly the administrator will be responsible to immediately remove and dispose any items that are not properly stored, will be expected to apply the progressive discipline to any staff responsible. Also, upon hire into a dining role all new staff will be trained on the Policy and Procedure Safe Food Storage, Handling, and Sanitation prior to working unsupervised. Documentation of this training will be kept in the Executive Directors office.

Proposed Overall Completion Date: 10/28/2025

Directed Completion Date: 10/28/2025

Not Implemented (██████ - 12/19/2025)

144c1 - Smoking Area Guidelines**16. Requirements**

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On the morning of 8/20/25, 4 faux leather cushioned chairs were present in the designated outdoor smoking area outside of Hallway A.

On the morning of 8/20/25, a folding chair with a fabric seat was present in the designated outdoor smoking area outside of Hallway D.

REPEAT VIOLATION: 3/10/2025; 12/19/2024

Plan of Correction

Accept (██████ - 09/26/2025)

On 08/20/25, immediately following the inspection, the faux leather cushioned chair and the folding fabric chair were removed from the designated smoking areas outside Hallway A and Hallway D. By 09/19/25, all residents received a notice from the Executive Director outlining permitted and prohibited furniture in smoking areas and reviewing 2600.144(c). The notice also provided 30 days' advance notice that, effective 10/20/25, smoking will be limited to one location: the patio off the Hallway D activity room. After this date, the Hallway A exterior smoking area will no longer be permitted.

On 09/19/25, the Executive Director also held a staff training on 2600.144(c). Documentation of staff education is maintained in the Administrator's office. The housekeeping department currently checks and empties smoking receptacles twice per shift at both locations and will continue to do so until the 30-day notice period ends. After 10/20/25, they will service only the Hallway D patio area, which will be marked with signage as the designated smoking area.

As part of this procedure, housekeeping will also check furniture during receptacle rounds to ensure only approved items remain in the designated smoking area.

144c1 - Smoking Area Guidelines (continued)

Licensee's Proposed Overall Completion Date: 09/24/2025

Implemented () - 12/19/2025)

185a - Implement Storage Procedures

17. Requirements

2600.

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

Description of Violation

Resident #2 is prescribed blood glucose checks once daily in the morning. According to Resident #2's glucometer, resident #2's blood glucose reading on the morning of 8/12/25 was 82; however, the reading was documented as 87 on resident #2's August 2025 medication administration record (MAR).

On 8/17/25, resident #2's August 2025 MAR indicates a blood glucose reading of 221; however, there is no blood glucose reading present on resident #2's glucometer on 8/17/25.

Resident #3 is prescribed blood glucose checks once daily in the morning. On 8/17/25, resident #3's August 2025 MAR indicates a blood glucose reading of 81; however, there is no blood glucose reading present on resident #3's glucometer on 8/17/25.

Resident #7 is prescribed blood glucose checks once daily in the morning. On 8/17/25, resident #7's August 2025 MAR indicates a blood glucose reading of 225; however, there is no blood glucose reading present on resident #7's glucometer on 8/17/25.

Plan of Correction

Accept () 09/26/2025)

On September 19, 2025, the Acting Administrator has a scheduled training and will review the cited deficiencies with all medication administration staff. Glucometers were immediately audited against MAR entries for accuracy, and staff involved in the identified discrepancies were re-educated on the requirement to enter readings in real time directly from the glucometer display. The root cause of this deficiency was that staff failed to verify and record glucometer readings directly from the device at the time of testing. In some instances, entries were made without an actual reading present in the glucometer's memory, resulting in inaccurate or missing documentation.

To correct this deficiency, a revised Policy and Procedure: Medication and Medical Equipment Storage and Use was created and implemented on September 19, 2025. The policy mandates secure storage, restricted access, real-time documentation of glucometer readings, and oversight checks to ensure compliance. All Med Techs, Nurses, and Wellness staff responsible for medication administration and blood glucose monitoring will be trained on the new policy and procedure by the Acting Administrator and Director of Wellness on 09/19/25. The training will cover proper use of glucometers, immediate and accurate documentation on MARs, and shift-end verification responsibilities. Training will be completed by September 19, 2025, and attendance will be documented on sign-in sheets and retained in staff files.

The Acting Administrator will ensure that the corrective action is fully implemented and sustained, and the Regional Director of Operations will review compliance as part of ongoing oversight. As of 09/24/25 The Administrator will

185a - Implement Storage Procedures (continued)

be responsible to complete a daily review of glucometers and blood sugar prescribed blood sugar checks daily for 1 week, weekly for 2 weeks then monthly thereafter.

Licensee's Proposed Overall Completion Date: 09/24/2025

Not Implemented [REDACTED] 12/19/2025)

187a - Medication Record**18. Requirements**

2600.

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

3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.

Description of Violation

Resident #6's August 2025 MAR includes Atorvastatin 40mg tablet-Take 1 tablet by mouth once daily at 5:00pm; however, this medication was discontinued on 4/30/25.

REPEAT VIOLATION: 3/10/2025; 12/19/2024

Plan of Correction

Directed [REDACTED] 09/26/2025)

Resident #6's discontinued medication was not in the medication cart at the time of inspection, but the mar indicated the medication was administered. The pharmacy was notified immediately to remove the medication off the MAR. Therefore, the staff persons responsible for marking the MAR was educated on proper medication administration by the Administrator on 08/23/25 to include not checking off the MAR without verifying the list against all the residents' medications as per the administration guidelines. This documentation will be kept on file in the office. On or before 10/03/25 the DOW and Administrator will hold a training with all medication technicians to ensure proper administration guidelines and will ensure that order for any discontinued medications are removed from the EMAR by the contacting the pharmacy to have the medication order removed from the profile. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. LM 9/26/25). The Administrator and DOW will immediately audit the med carts and will perform med cart audits weekly for the next 2 months then biweekly to stay in compliance. (DIRECTED: The administrator/DOW reviews shall begin on 9/30/25 and shall also include a review of each resident's MAR to ensure accuracy and completeness in accordance with 2600.187a. [REDACTED] 9/26/25). Documentation will be kept in the office.

Proposed Overall Completion Date: 09/25/2025

Directed Completion Date: 10/03/2025

Not Implemented [REDACTED] 12/19/2025)

187b - Date/Time of Medication Admin.

19. 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

On 4/30/25, resident #6's Atorvastatin-40mg tablet was discontinued; however, this medication was documented as administered on resident #6's August 2025 MAR daily from 8/1/25 through 8/20/25, as well as on 8/22/25 through 8/24/25.

REPEAT VIOLATION: 12/19/2024

Plan of Correction

Directed [REDACTED] 09/26/2025)

Resident #6's discontinued medication was not in the medication cart at the time of inspection, but the mar indicated the mediation was administered. Therefore, the staff persons responsible for marking the MAR was educated on proper medication administration by the Administrator on 08/23/25 to include not checking off the MAR without verifying the list against all the residents' medications as per the administration guidelines. On or before 10/03/25 the DOW or Administrator will hold a training with all medication technicians to ensure proper administration guidelines and will ensure that order for any discontinued medications are removed from the EMAR by the contacting the pharmacy to have the medication order removed from the profile. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 9/26/25). The process to ensure long term success is that the Director of Wellness or Assistant will be responsible to print a daily report of any discontinued medications and issue to medtechs the daily report which medication (s) have been discontinued. The DOW or Wellness Assistant will be responsible to immediately remove the discontinued medication(s) from the cart and remove and order from the EMAR in addition to contacting the pharmacy. This process will be reviewed with the Director of Wellness, Assistant and all Medtech's by 10/03/25 at which time it will be fully implemented.

DIRECTED: Beginning on 9/30/25: The administrator/designee shall review all resident MAR's weekly for 2 months then bi-weekly thereafter to ensure accurate and complete medication administration documentation is present in accordance with 2600.187b. [REDACTED] 9/26/25

Proposed Overall Completion Date: 10/03/2025

[REDACTED]

[REDACTED]

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

Facility Information

Name: *STERLING HOME* License #: *45269* License Expiration: *12/04/2025*
Address: *1318 ARCH STREET, MCKEESPORT, PA 15132*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *STERLING HOME LLC*

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: Total Daily Staff: *40* Waking Staff: *30*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Provisional, Monitoring* Exit Conference Date: *11/17/2025*

Inspection Dates and Department Representative

11/17/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42* Residents Served: *37*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *25* Are 60 Years of Age or Older: *34*
Diagnosed with Mental Illness: *29* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *3* Have Physical Disability: *2*

Inspections / Reviews

11/17/2025 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/04/2025*

Inspections / Reviews (*continued*)

12/05/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/12/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 12/11/2025

12/11/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/12/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 12/18/2025

12/19/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/12/2025

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

18 - Compliance With Laws

1. Requirements

2600.

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

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16, requires the date of battery installation to be present on the battery of all battery-operated carbon monoxide detectors; however, at the time of inspection, no date of battery installation was present on the battery-operated carbon monoxide detector located outside of the front lobby in the A Hallway.

REPEAT VIOLATION: 12/19/2024

Plan of Correction

Directed (████) 12/11/2025)

Attached is a copy of the facilities Policy and Procedure for Carbon Monoxide Detector Inspection that took effect 9/19/2025. As per the Policy The maintenance person is responsible for monthly functional test, verify batteries are operable, and to replace batteries as needed and will label the detectors when the battery is changed with the date. All carbon monoxide detectors are being checked weekly and are noted on the maintenance log that is attached and has been in effect since 9/25/2025. All carbon monoxide detectors have a tag on the outside cover displaying the date new batteries were put in. The weekly maintenance logs ensure the date of battery installation is present on all battery operated carbon monoxide detectors. The Admin verifies the maintenance log and initials weekly that all has been completed.

On 11/17/25 immediately following the inspection the Maintenance Associate added a label to the detector to ensure full compliance with The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16. Additionally, on 11/18/25 the Administrator and Maintenance Director reviewed the The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16 to ensure full understanding of all facets of this regulation and acknowledged understanding. The Administrator also updated the log to ensure acknowledgement of a label being affixed to the detector as per the The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16 to ensure ongoing compliance All records will be kept in the Administrator's office. Any issues identified will be corrected immediately and addressed with staff as needed. Lastly, the community revised the current Carbon Monoxide Detector Policy to be more in alignment

Proposed Overall Completion Date: 01/01/2026

Directed Completion Date: 12/11/2025

Not Implemented (████) 12/19/2025)

101j3 - Bed/Linens/Pillows/Blankets

2. Requirements

2600.

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

101.j. Each resident shall have the following in the bedroom:

3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

At approximately 9:30am, no fitted sheet was present on resident #1's bed.

At approximately 9:30am, no fitted sheet or pillow cases were present on resident #2's bed.

At approximately 9:40am, no pillow was present on resident #3's bed.

REPEAT VIOLATION: 12/19/2024

Plan of Correction

Directed [REDACTED] 12/11/2025)

The Administrator brought the new linens into the facility on November 24, 2025, and is continuing to order linens weekly to ensure compliance with having extra's in the building at all times. Daily checks started November 19, 2025 with housekeeping documenting on their daily log sheet. Documentation is attached. The housekeeping log sheets are kept in the office in a binder. The Administrator had an education with all employees on December 8, 2025 on pillows, bed linens and blankets being in good repair and all items being on the bed. Documentation is attached and kept in the administrator's office in accordance with 2600.65i.

The Administrator immediately went to the housekeeping department to get the housekeeper on duty to put a fitted sheet on both resident's #1 and #2's bed. Resident #2 also received a new pillow case. Resident #3 received a new pillow. The Administrator had the inspectors go back into all the rooms to show that the linens were taken care of prior to them leaving the facility.

Moving forward and to stay in compliance, the Administrator ordered and received new fitted sheets, flat sheets and pillows to ensure that there will always be extra linens and pillows at all times and educated staff that when removing soiled linen to wash they should immediately replace the existing bedding with a clean set.

Housekeeping is to check all rooms/beds daily to ensure clean linens and bedding is in good repair. A binder has been created for housekeeping and housekeepers are to sign daily that bedding is being checked. Documentation is attached.

The Administrator will check the binder and do a walk through daily to ensure bedding is being taken care of. The Admin started checking rooms daily on November 18, 2025 and will continue daily for the next month, then weekly starting January 1, 2025.

Proposed Overall Completion Date: 01/01/2026

Directed Completion Date: 12/11/2025

Not Implemented [REDACTED] 12/19/2025)

185a - Implement Storage Procedures

3. Requirements

2600.

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

Description of Violation

Resident #3 is currently prescribed blood glucose checks 4 times daily; however, resident #3's blood glucose readings

185a - Implement Storage Procedures (continued)

were not documented on resident #3's November 2025 medication administration record (MAR), to include the following dates/times:

- 11/10/25 at 12:00pm
- 11/8/25 at 7:30am
- 11/7/25 at 7:30am and 8:00pm

From 11/7/25 through 11/11/25, resident #4 was prescribed blood glucose checks 3 times daily; however, resident #4's blood glucose readings were incorrectly documented on resident #4's November 2025 MAR on numerous occasions, to include the following:

- On 11/10/25 at approximately 9:15am, resident #4's blood glucose was 195; however, was documented as 198 on resident #4's November 2025 MAR
- On 11/11/25 at approximately 5:30pm, resident #4's blood glucose was 212; however, was not documented on resident #4's November 2025 MAR

Resident #5 is currently prescribed blood glucose checks once daily in the morning. On 11/1/25 at approximately 10:00am, resident #5's blood glucose reading was 148; however, this reading was not documented on resident #5's November 2025 MAR.

Plan of Correction**Directed (██████ 12/11/2025)**

When performing glucometer checks daily, all glucometer readings are checked against the resident MAR to ensure accurate and complete blood sugar documentation is present. Documentation of Glucometer checks are being kept in the Wellness Office.

The Administrator immediately did a training on Safe storage, access and disposal of medications with all med passers on November 18, 2025 and had all persons who pass medications signed the training sheet and the individual training. Documentation is attached. Administrator also did a training on Blood glucose preparation, testing and recording on November 26, 2025. Documentation is attached.

A Diabetic class has also been scheduled for December 18, 2025 at 2:00 pm a Certified Diabetic Trainer, ████████

██████████ Documentation will be sent to DHS when completed to verify education.

To stay in compliance, moving forward, the Administrator and Resident Care Coordinator are performing med cart audits daily and checking glucometers daily to ensure that proper recording is being followed. These audits started November 18, 2025. Starting January 1, 2026 cart audits and glucometers will be performed weekly on Mondays.

Proposed Overall Completion Date: 01/01/2026

Directed Completion Date: 12/18/2025

Not Implemented (██████ - 12/19/2025)**186a - Authorized Prescriber****4. Requirements**

2600.

186a - Authorized Prescriber (continued)

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

Description of Violation

Numerous discrepancies were discovered by an agent of the Department between the pharmacy labels and November 2025 MAR for resident #5, to include the following; however, no current prescribers' orders for resident #5 were present in the home, so it is unable to be determined which are correct:

- A bottle containing Tamsulosin-0.4mg capsules was present in the home's medication cart with the pharmacy label indicating "Take 2 capsules by mouth daily"; however, this medication is not present on resident #5's November 2025 MAR*
- A bottle containing Olanzapine-10mg tablets was present in the home's medication cart with the pharmacy label indicating "Take 2.5 tablets (25mg total) by mouth at bedtime"; however, resident #5's November 2025 MAR indicates "Olanzapine-10mg tablet-Take 1/2 tablet (5mg total) at bedtime"*
- A bottle containing Hydrochlorothiazide-25mg tablets was present in the home's medication cart with the pharmacy label indicating "Take 1 tablet by mouth every day"; however, resident #5's November 2025 MAR indicates "Hydrochlorothiazide-25mg tablet-Take 1 tablet by mouth 2 times daily"*
- A tube of Diclofenac Sodium-1% gel was present in home's medication cart with the pharmacy label indicating "Apply topically to left hip 4 times daily as needed"; however, resident #5's November 2025 MAR indicates "Diclofenac Sodium-1% gel-Apply topically to left hip 4 times daily"*

Plan of Correction

Directed [REDACTED] - 12/11/2025)

A copy of resident #5's current physician orders has been put in the residents chart for documentation. Resident charts are located in the Wellness Office.

On 11/17/25, The Administrator and Resident Care Coordinator immediately called the VA where resident #5 gets there medication from and had them send over a current medication list to verify all current orders. The current medication list was sent to the house pharmacy for the changes to be made to the MAR upon receipt. Orders were updated/changed as needed to match the MAR and what is in the cart as of November 28, 2025.

Admin also educated all medication associates on having written orders from the Medical Provider for any changes/new orders or discontinued medications made to a residents MAR Education was held on November 18, 2025. Documentation is attached.

Moving forward to stay in compliance anytime there is a change to a medication or a new order for medication, the Admin and Resident Care Coordinator (RCC) will ensure the orders are given to one of us to check and will be responsible for putting the written order in the residents chart and updated on the MAR as soon as it is received. Initials from the Admin or RCC will be on the back of the written order.

Med cart audits are being performed daily until the end of December 2025 then weekly on a Monday starting January 1, 2026.

Proposed Overall Completion Date: 01/01/2026

Directed Completion Date: 12/11/2025

Not Implemented [REDACTED] 12/19/2025)

187a - Medication Record

5. Requirements

2600.

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

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

Description of Violation

On 11/6/25, resident #3 returned to the home from a rehabilitation center with new medication orders; however, at the time of inspection, the following medications were not present on resident #3's November 2025 MAR:

- Pantoprazole 40mg tablet-Take 1 tablet by mouth twice daily
- Vitamin D2 50,000 unit capsule-Take 1 capsule by mouth every week on Sunday
- Lispro Kwikpen insulin-Inject 6 units subcutaneously 3 times a day before meals

REPEAT VIOLATION: 3/10/2025; 12/19/2024

Plan of Correction

Directed [REDACTED] 12/11/2025)

The Administrator called the pharmacy and had Resident #3's MAR corrected and updated by 12/2/25. The Resident Care Coordinator or Administrator if RCC is off prints 5 resident MAR's when doing the cart audit to ensure accuracy and completeness with this regulation. The Administrator did a training/education with all med trained staff on December 8, 2025 in regards to medication record shall be kept for each resident for whom medications are administered. Documentation attached. Documentation of education will be kept in accordance with 2600.65i.

On 11/17/25, The Administrator called the pharmacy and spoke with the pharmacist Marissa in regards to resident #3's medication. The orders were sent to the pharmacy a third time to have the information updated and the medication sent to the facility.

Effective immediately, (November 18, 2025) when a resident returns from the hospital or rehab the Admin will get the discharge papers first to confirm any changes in medication and will initial the discharge papers. The orders will then be sent to the pharmacy for them to input the meds into the MAR and send the new medications to the facility. The orders will then be put in the residents chart by the RCC.

Moving forward and to stay in compliance the Admin/RCC will then check the MAR before the next med pass to make sure changes were made and the medication was sent to the facility.

Cart audits continue to be done daily until the end of December 2025 then weekly on Mondays starting January 1, 2026. Documentation will be kept of the audits in the Administrator's office.

Proposed Overall Completion Date: 01/01/2026

187a - Medication Record (*continued*)

Directed Completion Date: 12/18/2025

Not Implemented (████ - 12/19/2025)

187b - Date/Time of Medication Admin.

6. 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 #1's November 2025 MAR does not include the initials of the staff person who administered the following medications to resident #1:

- *Admelog Solostar 100 units/ml insulin-Inject 10 units subcutaneously with meals 3 times daily, which was not documented as administered on 11/10/25 at 11:30am and on 11/12/25 at 7:30am*
- *Aspirin 81mg tablet-Take 1 tablet by mouth daily, which was not documented as administered on 11/12/25 at 8:00am*
- *Benztropine 2mg tablet-Take 1 tablet by mouth daily, which was not documented as administered on 11/12/25 at 8:00am*

REPEAT VIOLATION: 12/19/2024

Plan of Correction

Directed █████ 12/11/2025)

Administrator did education on medication administration documentation procedures with all med trained staff on December 8, 2025. Attached is the documentation. All trainings are kept in a binder in the Admin's office in accordance with 2600.65i.

Resident Care Coordinator or Administrator if RCC is not available prints MAR's for 5 different residents daily to do a cart audit to ensure completeness and accuracy with this regulation and keeps documentation in the wellness office.

The Administrator immediately had a training on Blood Glucose - preparation, testing and recording on November 26, 2025 and a training on medication November 18, 2025. Documentation attached.

A Diabetic education class has been scheduled with a Certified Diabetic Trainer, █████ for December 18, 2025 for all med passers. Documentation will be sent to DHS as verification the class was completed.

Moving forward and staying in compliance, the Admin/RCC have been doing cart audits daily to ensure all residents, including resident #1 are receiving the medication that is prescribed and marking off they were given. Starting January 1, 2026 cart audits will be performed weekly on Mondays.

Proposed Overall Completion Date: 01/01/2026

Directed Completion Date: 12/18/2025

Not Implemented (████ 12/19/2025)

187d - Follow Prescriber's Orders

7. Requirements

187d - Follow Prescriber's Orders (continued)

2600.

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

Description of Violation

Resident #3 is currently prescribed blood glucose checks 4 times daily. At the time of inspection, resident #3's glucometer was inoperable. According to staff person A, resident #3's glucometer battery died on the morning of 11/17/25; however, no new battery was installed at the time of inspection and resident #3's blood glucose was not checked on 11/17/25 at 12:00pm.

On 11/6/25, resident #3 returned to the home [REDACTED] with new medication orders; however, at the time of inspection, the following medications were not present in the home and have not been administered to resident #3 since they were prescribed on 11/6/25:

- Pantoprazole 40mg tablet-Take 1 tablet by mouth twice daily*
- Vitamin D2 50,000 unit capsule-Take 1 capsule by mouth every week on Sunday*
- Lispro Kwikpen insulin-Inject 6 units subcutaneously 3 times a day before meals*

From 11/7/25 through 11/11/25, resident #4 was prescribed blood glucose checks 3 times daily; however, according to resident #4's glucometer, resident #4's blood glucose was not checked on numerous occasions, to include the following:

- On 11/10/25 at 12:00pm*
- On 11/9/25 at 12:00pm and 5:00pm*
- On 11/8/25 at 12:00pm and 5:00pm*

On 11/12/25, resident #4 was prescribed blood glucose checks once daily in the morning; however, according to resident #4's glucometer, resident #4's blood glucose was not checked on 11/12/25 and 11/16/25.

Plan of Correction

Directed ([REDACTED] 12/11/2025)

Resident #3's battery for their glucometer was delivered to the facility that night at 8 pm November 17, 2025 and put in their machine. Resident Care Coordinator and Admin checked all glucometers that day 11/17/25 to ensure they were working properly and had good batteries. After Medication review completed by pharmacy the medications for resident #3's MAR updated and meds brought to the facility by 12/2/25. To stay in compliance the Admin/RCC are monitoring glucometers daily, checking for documentation on the MAR and ensuring medications are in the facility and available for administration to the resident in accordance with prescriber's orders. Each audit consist of 5 different residents daily until the end of December 31, 2025, then weekly starting 1/1/26 by the RCC. Documentation of audits are kept in the Wellness office

The Administrator called the pharmacy and spoke with the pharmacist [REDACTED] in regards to resident #3's medication. The orders were sent to the pharmacy several times to have the information updated and the medication sent to the facility.

Effective immediately, (November 18, 2025) when a resident returns from the hospital or rehab the Admin will get the discharge papers first to confirm any changes in medication and will initial the discharge papers. The orders

187d - Follow Prescriber's Orders (continued)

will then be sent to the pharmacy for them to input the meds into the MAR and send the new medications to the facility. The orders will then be put in the residents chart by the RCC or Designee.

Moving forward and to stay in compliance the Admin/RCC will then check the MAR before the next med pass to make sure changes were made and the medication was sent to the facility.

The Administrator immediately had a training on Blood Glucose - preparation, testing and recording on November 26, 2025 and a training on medication November 18, 2025. Documentation attached.

The facility has ordered and keeps extra batteries for the glucose machines in the facility at all times now. The extra batteries are kept in the med cart.

Proposed Overall Completion Date: 01/01/2026

Directed Completion Date: 12/18/2025

Not Implemented  **- 12/19/2025)**