

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

November 7, 2025

[REDACTED]  
VS WALLINGFORD LLC  
[REDACTED]

RE: CHESTNUT RIDGE RETIREMENT  
LIVING  
2700 CHESTNUT PARKWAY  
CHESTER, PA, 19086  
LICENSE/COC#: 14141

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/21/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,  
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: CHESTNUT RIDGE RETIREMENT LIVING License #: 14141 License Expiration: 01/30/2026  
 Address: 2700 CHESTNUT PARKWAY, CHESTER, PA 19086  
 County: DELAWARE Region: SOUTHEAST

**Administrator**

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

**Legal Entity**

Name: VS WALLINGFORD LLC  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 05/19/1997 Issued By: CWOPA L&I

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 83 Waking Staff: 62

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Incident Exit Conference Date: 08/21/2025

**Inspection Dates and Department Representative**

08/21/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: 130 Residents Served: 49  
 Secured Dementia Care Unit  
 In Home: Yes Area: SCDU Capacity: 50 Residents Served: 20  
 Hospice  
 Current Residents: 9  
 Number of Residents Who:  
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 66  
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 34 Have Physical Disability: 2

**Inspections / Reviews**

08/21/2025 Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 09/20/2025

09/22/2025 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: 10/08/2025  
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 09/27/2025

Inspections / Reviews (*continued*)

## 09/29/2025 POC Submission

Submitted By: [REDACTED] Date Submitted: 10/08/2025

Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 10/09/2025

## 11/07/2025 Document Submission

Submitted By: [REDACTED] Date Submitted: 10/08/2025

Reviewer: [REDACTED] Follow Up Type: Not Required

25b - Contract Signatures

1. Requirements

2600.

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

Description of Violation

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

Repeat Violation: [REDACTED]

Plan of Correction

Accept [REDACTED] - 09/29/2025)

Immediate Actions:

Action Plan 1: Ensure all resident-home contracts are fully executed as required by regulation 2600.25b.

Steps:

Identify and retrieve the incomplete contract for resident [REDACTED] immediately.

Obtain/attempt to get signature from resident

Responsible Party: Executive Operations Officer or Designee

Timeline: Completed on 9/14/25

Action Plan 2: Implement Staff Training on obtaining Resident signature/giving Resident the option.

Steps:

Reeducate Community Relations Director and Administrative Services Director on the regulatory requirements for contract execution to prevent future omissions.

Conduct a training session for the Administrative Service Director and Community Relations Director on the contract signing process and legal requirements.

Responsible Party: Executive Operations Officer or Designee

Timeline: Completed on 9/12/25

Long Term Actions:?

Action Plan 1: Maintain compliance with Regulation 2600.25b

Steps:

Ensure that all resident contracts are not missing signatures or other required elements.

Conduct an audit of all resident-home contracts to identify any additional discrepancies.

Responsible Party: Administrative Services Director or Designee

Timeline: Completion Date 9/30/25

Action Plan 2: Conduct monthly audit of new resident contracts to ensure compliance with regulation 2600.25b.

Steps:

Audits will be reviewed at monthly QAPI meeting for a period of six months, beginning October 1, 2025.

Responsible Party: Administrative Services Director or Designee

Timeline: Completion Date 10/1/25

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

Implemented [REDACTED] - 11/07/2025)

## 42b - Abuse

**2. 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] at 8:10pm, resident [REDACTED], who resides in the home's secured dementia care unit (SDCU), exited through the home's main entrance door ambulating with their cane, making a left into the parking lot towards Chestnut Parkway. The main entrance door is normally locked at 8pm, however on [REDACTED], the door was locked at 8:21pm by staff person A. At 8:24pm, while staff person A was outside conversing with residents from independent living, a vehicle approached and informed staff person A that a resident was at the end of the parking lot asking for a ride. In response, staff person A ran towards the resident after noticing that the resident [REDACTED] was outside the home without supervision. Resident [REDACTED]'s assessment and support plan (RASP), dated [REDACTED], indicates that the resident requires 24-hour supervision. Staff person B assisted in redirecting the resident back into the building, and assessed the resident's health status and took [REDACTED] vital signs; the resident told the staff that they were trying to catch a ride. The resident suffered no apparent injury. It's unknown how the resident was able to access the elevator on the 4th floor of the secured dementia care unit and exit the home; a code is required to enter the elevator from the SDCU. On [REDACTED], two staff persons were present on the 4th floor assisting other residents around 8pm and were unaware that resident [REDACTED] exited the SDCU. Staff interviews report that the resident has consistent exit-seeking behaviors; however, the resident's RASP dated [REDACTED] did not include this need or a plan to meet this need.

Repeat Violation: [REDACTED], et al.

**Plan of Correction**

Accept ([REDACTED] - 09/29/2025)

*Immediate Actions:*

*Action Plan 1: Improve the security measures to prevent unauthorized resident exits from the SDCU.*

*Steps:*

*Review and reinforce the policy on securing main entrance/exit doors.*

*Modify the elevator security code monthly.*

*Reeducate staff on emergency procedures to ensure immediate action in case of potential unauthorized exit of an SDCU Resident.*

*Responsible Party: Executive Operations Officer and Safety & Maintenance Engineer*

*Timeline: Completion Date 9/16/25*

*Action Plan 2: Ensure all staff are trained to effectively supervise and respond to residents' exit-seeking behaviors.*

*Steps:*

*Conduct training on identifying and managing exit-seeking behavior among residents.*

*Responsible Party: Executive Operations Officer or Designee*

*Timeline: Completed on 8/5/25*

42b Abuse (continued)

Action Plan 3: Ensure resident assessments and support plan (RASP) reflect current needs, including exit seeking behavior.

Steps:

Conduct a thorough reassessment of Resident [REDACTED] to include exit seeking behavior.

Communicate the updated RASP to all relevant staff members immediately.

Responsible Party: Life Stories Director

Timeline: Completed on 8/22/25

Long Term Actions:

Action Plan 1: Maintain a high standard of supervision quality.

Steps:

Encourage SDCU staff feedback on current safety measures and suggested improvements.

Educate staff and implement monthly elopement drills for SDCU staff to practice emergency response procedures beginning 10/8/25.

Review the audit records in monthly QAPI meeting for a period of six months, beginning October 1, 2025.

Responsible Party: Administrative Services Director and Life Stories Director or Designees

Timeline: Completion Date 10/8/25

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

Implemented [REDACTED] - 11/07/2025)

63b - Current First Aid Training

3. Requirements

2600.

63.b. Current training in first aid and certification in obstructed airway techniques and CPR shall be provided by an individual certified as a trainer by a hospital or other recognized health care organization.

Description of Violation

The following staff obtained CPR/First Aid Certifications from training sources that are not certified as trainers by a hospital or other recognized health care organization:

- Staff person C was trained in CPR First Aid by save a life certifications by NHCPS.
- Staff person D was trained in CPR First Aid by American CPR Care Association
- Staff person E was trained in CPR by American CPR Care Association
- Staff person F was trained in CPR by National CPR Foundation

Plan of Correction

Directed [REDACTED] - 09/29/2025)

Immediate Actions:

Action Plan 1: Ensure all staff have valid certifications from recognized trainers.

Steps:

Identify all staff who have acquired CPR/First Aid certifications from unapproved sources.

Schedule in person recertification sessions with trainers certified by recognized healthcare organizations.

Complete re certification for Staff persons C, D, E, and F.

Maintain documentation of valid CPR/First Aid certifications for all staff.

Responsible Party: Administrative Services Director or Designee

Timeline: Completion Date 10/16/25

63b Current First Aid Training (continued)

Long Term Actions:

Action Plan 1: Ensure ongoing compliance regulation 2600.63b.

Steps:

Conduct monthly audits to review staff CPR/First Aid certifications.

Compare certifications against the list of approved trainers.

Address any discrepancies immediately by scheduling re certification if necessary.

Audits will be reviewed monthly at QAPI for ongoing compliance for a period of six months, beginning October 16, 2025.

Responsible Party: Administrative Services Director or Designee

Timeline: Completion Date 10/16/25

Proposed Overall Completion Date: 10/16/2025

Directed Plan of Correction (9/29/25 [redacted])

Immediately, the administrator shall review the staffing schedule at least weekly to ensure that sufficient staff certified in CPR/First aid are scheduled. The administrator shall ensure that substitute personnel filling in for a CPR trained staff person shall have the required CPR/First Aid certifications.

Directed Completion Date: 10/08/2025

Implemented [redacted] - 11/07/2025)

65e - 12 Hours Annual Training

4. Requirements

2600.

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

1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person B received 0 hours of annual training in training year 2024.

Repeat Violation: [redacted], et al.

Plan of Correction

Accept [redacted] - 09/29/2025)

Immediate Actions:

Action Plan 1: Ensure all direct care staff are on track with their annual 2025 training requirements.

Steps:

Conduct an audit of all direct care staff training records for compliance.

Update the annual 2025 training schedule to accommodate any missed training sessions.

Responsible Party: Administrative Services Director or Designee

Timeline: Completion Date 9/30/25

Long Term Actions:

Action Plan 1: Review staff records monthly and ensure that annual training hours are completed for the calendar year.

65e - 12 Hours Annual Training (continued)

Steps:

Offer specialized training sessions based on direct care staff feedback and job evaluations.

Additional training sessions will be offered during the month of December 2025 to maintain compliance of regulation 2600.65e

Audits will be reviewed during the monthly QAPI meeting beginning October 1, 2025.

Responsible Party: Administrative Services Director of Designee

Timeline: Completion Date 10/1/25

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

Implemented [redacted] - 11/07/2025)

105g - Lint Removal and Duct Cleaning

5. Requirements

2600.

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

Description of Violation

On [redacted], there was an approximate 1-inch accumulation of lint in the lint trap of the 5th floor dryer. There were no clothes in the dryer at the time.

Plan of Correction

Accept ( [redacted] - 09/29/2025)

Immediate Actions:

Action Plan 1: Lint was immediately removed from the affected dryer lint trap.

Steps:

Instruct staff to immediately check and clear lint traps on all dryers.

Document the completion of lint removal and inspection in the Lint Trap Log.

Responsible Party: Hospitality Executive Associate

Timeline: Completed on 8/21/25

Action Plan 2: Reeducate all relevant staff on proper maintenance of dryers to prevent fire hazards.

Steps:

Organize a training session on proper lint removal and dryer maintenance protocols.

Include hands-on demonstration on cleaning lint traps.

Require staff to sign an acknowledgment of understanding the procedures.

Implement Daily Lint Trap Logs to monitor compliance with regulation 2600.105g.

Conduct Audit of Daily Lint Trap Logs daily for four weeks, weekly for four weeks, then monthly to ensure compliance with regulation 2600.105g.

Lint Trap Logs and Audits will be reviewed monthly during QAPI for ongoing compliance, for a period of six months beginning with the September 2025 meeting.

Responsible Party: Safety & Maintenance Engineer or Designee

Timeline: Completed on 9/1/25

Long Term Actions:

Action Plan 1: To maintain ongoing compliance with dryer lint maintenance and safety guidelines.

Steps:

105g - Lint Removal and Duct Cleaning (continued)

Establish a schedule for quarterly inspections and cleaning of dryer vent ducts.

Record each inspection and cleaning session in TELS.

Responsible Party: Safety & Maintenance Engineer or Designee

Timeline: Completion Date 8/29/25

Licensee's Proposed Overall Completion Date: 09/25/2025

Implemented [redacted] - 11/07/2025)

185a - Implement Storage Procedures

6. 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 [redacted] is prescribed [redacted] one tablet by mouth twice daily and as needed for anxiety. On [redacted] the initial count of tablets was not documented on the narcotic control sheet prior to the administration of the medication at 10:22am.

The home's-controlled substance policy, under "Charting Narcotic and Controlled Substances on the MAR and the Control Sheet" states that "narcotic count will be between two (2) authorized trained team members, and reconciled at the beginning and end of the shift."

Plan of Correction

Accept [redacted] - 09/29/2025)

Immediate Actions:

Action Plan 1: Re-educate Nursing Staff on safe medication administration and documentation procedures.

Steps:

Conduct a review session with all staff involved in medication administration compliance of regulation 2600.185.a.

Provide training on the importance of documenting narcotic counts before administration.

Ensure understanding of the procedure requiring two authorized staff for reconciliation of narcotic counts.

Responsible Party: Corporate Wellness and Operation Specialist or Designee

Timeline: Completed on 9/16/25

Action Plan 2: Reaffirm the controlled substance policy to ensure all nursing staff remain in compliance.

Steps:

Conduct an immediate policy review focusing on the controlled substances and medication administration.

Distribute a policy memo highlighting the specific issue to all nursing staff.

Responsible Party: Executive Operations Officer or Designee

Timeline: Completed on 9/5/25

Long Term Actions:

185a Implement Storage Procedures (continued)

Action Plan 1: Ensure ongoing compliance and proper documentation of medication counts.

Steps:

An updated Electronic MAR system was implemented on 9/15/25

Establish a weekly audit schedule for Narcotic Control and MARs for next three months.

Create a checklist for compliance that includes two signatures and correct count recording.

Review audit findings during monthly QAPI meetings to ensure ongoing compliance, for a period of six months, beginning October 1, 2025.

Responsible Party: Executive Operations Officer

Timeline: 10/1/25

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

Implemented ( ) - 11/07/2025

201 - Positive Interventions

7. Requirements

2600.

201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident consistently exhibits exit seeking behaviors. On at 3:20pm, resident was observed sitting in the common area with other residents and staff person D. When resident got up from the chair and walked towards the elevator, staff person D ran to the elevator and stood in front with hands extended across, blocking the elevator to prevent the resident from getting on the elevator if it opened. Resident asked the staff, "Why do you keep doing that?" and was becoming agitated. Staff D responded, "What am I doing?" The resident responded, "You know what you're doing." The staff person did not redirect the resident or attempt any safe management techniques to modify or eliminate this behavior of exit seeking.

Plan of Correction

Accept ( ) - 09/29/2025

Immediate Actions:

Action Plan 1: Ensure all SDCU direct care staff are proficient in utilizing positive interventions for managing resident behaviors.

Steps:

Schedule a training session on positive intervention techniques like redirection and de escalation specifically focused on exit seeking.

Provide SDCU direct care staff with a pocket guide highlighting Challenging Demetia Behaviors Intervention Techniques.

Provide SDCU direct care staff with additional interactive activities and supplies catered to the Residents' interests to promote effective and positive engagement.

Responsible Party: Life Stories Director or Designee

Timeline: Completed on 8/5/25

201 - Positive Interventions (continued)

Long Term Actions:

Action Plan 1: Create a structured process for monitoring and documenting resident behavioral issues.

Steps:

Develop a standardized behavioral monitoring form that logs all instances of exit-seeking behavior and staff responses.

Train SDCU direct care staff on accurately completing these reports and maintaining resident confidentiality.

Review reports at monthly QAPI for a period of six months, beginning with October review on 11/5/25, to address any behavioral issues identified.

Responsible Party: Life Stories Director or Designee

Timeline: Completion Date 10/1/25

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

Implemented [redacted] 11/07/2025)

225c - Additional Assessment

8. Requirements

2600.

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

- 2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [redacted]'s most recent assessment was completed on [redacted] indicates that resident has a need for extensive supervision. However, the resident's support plan does not include an assessment of this need nor how this need will be met. The resident uses a cane for mobility; however, the device is not mentioned on the assessment or how the need will be met.

Several other areas of the support plan do not include an assessment of the resident's need, to include: Engaging in social and leisure activities (prompting/cueing - B), orientation to time, place, and person (C-moderate problem), and agitation (assessment states "redirect").

Repeat Violation: [redacted] et al, [redacted], et al.

Plan of Correction

Accept [redacted] - 09/22/2025)

Immediate Actions:

Action Plan 1: Ensure Resident [redacted] needs are accurately assessed and documented in RASP.

Steps:

Conduct a comprehensive re-assessment of Resident [redacted] to ascertain all current needs, especially concerning supervision, mobility aid use, and social activity engagement.

Document all findings in the RASP, emphasizing how each need will be met and specify the supervision required.

Communicate the updated assessment and plan to all relevant direct care staff to ensure understanding and compliance.

Responsible Party: Life Stories Director or Designee

Timeline: Completed on 8/22/25

225c Additional Assessment (continued)

Action Plan 2: Re educate Life Stories Director on the importance of timely assessments for changes in resident condition.

Steps:

Organize a training session on recognizing significant changes in resident conditions and the importance of updating assessments promptly.

Emphasize documentation standards and accuracy to ensure care plans reflect current residents' needs.

Responsible Party: Executive Operations Officer or Designee

Timeline: Completed on 8/29/25

Action Plan 3: Ensure current assessments for all residents are up to date and accurately reflect residents' needs.

Steps:

Conduct an audit of all current resident RASPs to ensure compliance with regulation 2600.225c.

Identify any gaps in assessments and initiate immediate updates where necessary.

Prioritize the assessments of residents exhibiting significant changes in conditions.

Review of the audit will be reviewed in the monthly QAPI meeting, for a period of six months, beginning with September review in the 10/1/25 meeting.

Responsible Party: Resident Wellness Director or Designee

Timeline: Completion Date 10/1/25

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

Implemented [redacted] - 11/07/2025)

227d - Support Plan Medical/Dental

9. Requirements

2600.

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

Description of Violation

The assessment for resident [REDACTED], dated [REDACTED], indicates the resident has a need for aggression and states that gets aggressive when [REDACTED] wants to leave". The resident's support plan, dated [REDACTED] does not document how this need will be met.

Plan of Correction

Accept [REDACTED] - 09/22/2025)

Immediate Actions:

Action Plan 1: Ensure Resident [REDACTED]s most current RASP documents how the need for aggression will be met.

Steps:

Review the most current RASP of Resident [REDACTED] to identify specific needs related to aggression.

Consult with the resident's physician or certified nurse practitioner to determine suitable interventions or referrals.

Communicate changes to the care team and ensure comprehension of the new interventions.

Responsible Party: Life Stories Director or Designee

Timeline: Completed 8/22/25

Action Plan 2: Ensure compliance with documentation requirements for all residents.

Steps:

Conduct a full audit of current resident RASPs to identify similar documentation gaps.

Review the audit findings and prioritize immediate corrections.

Audit results will be reviewed during monthly QAPI, for a period of six months, beginning with September review on 10/1/25.

Responsible Party: Executive Operations Officer or Designee

Timeline: Completion Date 10/1/25

227d - Support Plan Medical/Dental (continued)

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

Implemented [redacted] - 11/07/2025)

236 - Staff Training

10. Requirements

2600.

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

Description of Violation

Direct care staff person B, who works in the Secure Dementia Care Unit (SDCU) had only 0 hours of training in dementia care during the 2024 training year.

Repeat Violation: [redacted] et al., [redacted] et al., [redacted]

Plan of Correction

Accept [redacted] - 09/22/2025)

Immediate Actions:

Action Plan 1: Ensure immediate compliance with the mandatory training requirements for Staff Person B.

Steps:

Review current training records for Staff Person B.

Schedule and provide training session for Staff Person B.

Ensure Staff Person B completes the required 6 hours of training for the 2025 calendar year.

Document completion of training in Staff Person B's personnel file and update training records accordingly.

Responsible Party: Life Stories Director or Designee

Timeline: Completion Date 9/30/2025

Long Term Actions:

Action Plan 1: Implement an Annual Training Schedule.

Steps:

Develop an annual training calendar that includes all mandatory training sessions.

Communicate the schedule to all SDCU staff and management.

Track compliance through hardcopy training log.

Responsible Party: Life Stories Director or Designee

Timeline: Completed 9/1/25

Action Plan 2: Conduct Audit and Review of Staff Training Compliance.

Steps:

Conduct monthly audit of all employee files to review training status of all Direct Care Staff.

Identify any staff that are out of compliance and ensure completion of required training(s).

Ensure certificate or documentation of completion is on file.

New Team members will complete mandatory training as part of their general Orientation/Onboarding process.

Audits will be reviewed in QAPI monthly, for a period of six months, beginning with the September 2025 meeting.

Responsible Party: Life Stories Director or Designee

Timeline: Completion Date 10/1/25

236 Staff Training (continued)

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

Implemented (█ - 11/07/2025)

251b - Record Entries Legible

11. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident █ is prescribed █ give one tablet by mouth twice daily and as needed for anxiety. The controlled inventory sheets write overs on the tablets remaining on the following dates: █ at 7:16pm, █ at 2:07pm, █ at 9:30 am or pm not documented.

Resident █ is prescribed █ give one tablet by mouth twice daily and as needed for anxiety. There was a write over date on the controlled inventory sheet on █ at 9:49am.

Plan of Correction

Accept █ - 09/29/2025)

Immediate Actions:

Action Plan 1: Ensure all medication records are permanent, legible, dated, and signed without overwriting.

Steps:

Re educate all nursing staff on proper documentation techniques for medication entries.

Implement a double check system for medication entries for the next 30 days to catch and correct any errors immediately.

Responsible Party: Corporate Wellness and Operation Specialist or Designee

Timeline: Completed on 9/16/25

Action Plan 2: Reinforce proper documentation practices among nursing staff.

Steps:

Conduct a training session on proper documentation, stressing the importance of permanent and legible records.

251b - Record Entries Legible (continued)

Distribute written guidelines on medication record-keeping to all nursing staff.

Evaluate staff understanding through a brief quiz or practical demonstration.

Responsible Party: Resident Wellness Director or Designee

Timeline: Completion Date 9/19/25

Long Term Actions:

Action Plan 1: Maintain compliance of medication records through ongoing quality assurance activities.

Steps:

Electronic MAR system implemented on 9/15/25.

Conduct monthly audits of resident medication records to ensure compliance with regulation 2600.251b.

Review audits during monthly QAPI meeting, for a period of six months, to ensure ongoing compliance, beginning October 1, 2025.

Responsible Party: Resident Wellness Director or Designee

Timeline: Completion Date 10/1/25

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

Implemented [redacted] 11/07/2025)