

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

January 28, 2026

[REDACTED]
THE NEW HERITAGE TOWERS INC
[REDACTED]
[REDACTED]

RE: WESLEY ENHANCED LIVING
DOYLESTOWN
200 VETERANS LANE
DOYLESTOWN, PA, 18901
LICENSE/COC#: 12718

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/08/2025, 09/09/2025 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: WESLEY ENHANCED LIVING DOYLESTOWN **License #:** 12718 **License Expiration:** 07/05/2026
Address: 200 VETERANS LANE, DOYLESTOWN, PA 18901
County: BUCKS **Region:** SOUTHEAST

Administrator

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

Legal Entity

Name: THE NEW HERITAGE TOWERS INC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 06/08/2021 **Issued By:** L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 51 **Waking Staff:** 38

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 09/09/2025

Inspection Dates and Department Representative

09/08/2025 - On-Site: [REDACTED]
09/09/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 75 **Residents Served:** 49

Secured Dementia Care Unit

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

Hospice

Current Residents: 1

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 49
Diagnosed with Mental Illness: 1 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 2 **Have Physical Disability:** 0

Inspections / Reviews

09/08/2025 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 10/03/2025

10/07/2025 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 10/28/2025
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 10/12/2025

Inspections / Reviews *(continued)*

10/21/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/28/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/28/2025

01/28/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/28/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On [REDACTED], resident medical information was left on a clipboard unlocked and unattended on top of the third-floor medication cart.

On [REDACTED] at 10:11am, the narcotics logbook was found unlocked and unattended on top of the second-floor medication cart.

Plan of Correction

Accept ([REDACTED] - 10/21/2025)

The Personal Care Staff were retrained on 2600 Reg.17, between 9/10/25 and 9/12/25. All Staff acknowledged understanding. The PCHA and the Medical Records Coordinator will do audits of the Medication Carts for compliance with 2600 Reg. 17 beginning the week of 10/6/25 every two weeks until 11/1/25. Then beginning the month of November 2025, the PCHA or the Medical Records Coordinator will Quality Review the Nurses' Desk and the Medication Carts monthly until 3/31/26. The results of the audits will be reviewed at Monthly Staff meetings and audit feedback will be given as appropriate.

Licensee's Proposed Overall Completion Date: 10/27/2025

Implemented ([REDACTED] 01/28/2026)

26b - Quality Management Plan Content

2. Requirements

2600.

- 26.b. The quality management plan shall address the periodic review and evaluation of the following:
 - 1. The reportable incident and condition reporting procedures.
 - 2. Complaint procedures.
 - 3. Staff person training.
 - 4. Licensing violations and plans of correction, if applicable.
 - 5. Resident or family councils, or both, if applicable.

Description of Violation

The home's quality management review dated [REDACTED] did not address the reportable incident and condition reporting procedures, complaint procedures, staff person training or licensing violations and plans of correction, if applicable.

Plan of Correction

Accept ([REDACTED] - 10/21/2025)

The Quality Management Team is comprised of the PCHA, the Medical Records Coordinator, the Dayshift Lead Med Tech, and the Personal Care Unit Coordinator. The Quality Management Team met on 10/2/25 and reviewed/evaluated the Reportable Incidents for the month; Complaint procedures; staff person training; and Licensing violations/plan of correction. The Quality Management Team will meet monthly and record meeting notes.

The Quality Management Team is comprised of the PCHA, the Medical Records Coordinator, the Dayshift Lead Med Tech, and the Personal Care Unit Coordinator.

26b - Quality Management Plan Content (continued)

The Quality Management Team met on 10/2/25 and reviewed/evaluated the Reportable Incidents for the month; Complaint procedures; staff person training; and Licensing violations/plan of correction. The Quality Management Team has developed a plan to meet monthly and record meeting notes. The Quality Management Plan was updated on 10/2/25 and includes:

1. Review/Evaluation of the following topics:

- a) Reportable Incidents for the month.
- b) Any Complaint procedures.
- c) Staff training.
- d) Licensing violations/plan of correction.
- e) Resident Fall Incidents

2. Details of how compliance will be maintained:

To ensure compliance is maintained PCHA will provide the follow up after every monthly meeting within 10 days, with ongoing education and retraining.

Licensee's Proposed Overall Completion Date: 10/12/2025

Implemented [redacted] - 01/28/2026)

65b - Rights/Abuse 40 Hours

3. 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

Staff person A completed [redacted] 40th scheduled work hour on approximately [redacted]; however, this staff person did not complete training in the following topics: Resident rights; Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Staff person B completed [redacted] 40th scheduled work hour on approximately [redacted]; however, this staff person did not complete training in the following topics: Reporting of reportable incidents and conditions.

Plan of Correction

Accept [redacted] - 10/21/2025)

Staff Person A (substitute staff member) was immediately trained on Resident Rights and Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act. A new process for Substitute Staff Training was implemented on 9/10/25. The Personal Care Unit Clerk will ensure that Substitute Staff complete the trainings in Regulation 65b. The back-up staff for this will be the PCHA. The PCHA will do monthly audits of the substitute staff's Training Records to ensure compliance with 65b. The audit results will be reviewed/evaluated in the monthly Quality Management Team meeting and quarterly Quality Assurance meeting which includes Personal Care Administrator

65b - Rights/Abuse 40 Hours (continued)

and Executive Director.

Our training platform was updated for ancillary staff (including Staff Person B) to include Reportable Incidents and Conditions. All ancillary staff will complete this training by end of day 10/6/25 and annually thereafter.

Staff Person A was trained by the PCHA.

The monthly audits started 9/10/25.

Effective 9/10/25, when the Personal Care Unit Clerk (PCUC) schedules a Substitute/Agency Staff, [REDACTED] follows the process below:

- 1) PCUC will review the current Substitute/Agency Staff List to determine if training will be required before substitute/agency staff can be assigned). If the PCUC determines that Substitute/Agency staff requires training, [REDACTED] will follow the process below: a) Fire Safety and emergency preparedness procedures and recognition and response to crises and emergency situations – On the day that the Substitute/Agency Staff accepts a shift in PC, the PCUC will schedule the training with a Fire Safety Expert (Security Guard A, or the Director of Facility Operations, or the Maintenance Coordinator). b) On the day that the Substitute/Agency Staff accepts a shift in PC the PCUC will schedule the training for: Resident rights, the Older Adult Protective Services Act, Falls and accident prevention and new population groups that are being served at the home that were not previously served, if applicable (before the Substitute/Agency Staff starts their shift) – these trainings will be done by the PCHA, LPN or a Lead PC Med Tech. c) The PCUC will update the Substitute/Agency Staff List with the training dates. d) Trainings will be done annually.

The PCHA will present the audit results at the monthly QMT meeting (next meeting is 11/13/25) and the quarterly Quality Assurance Meetings (next meeting is 10/16/25).

Licensee's Proposed Overall Completion Date: 10/11/2025

Implemented ([REDACTED] - 01/28/2026)

96a - First Aid Kit

4. Requirements

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On [REDACTED] the first aid kit in the main kitchen area did not include tweezers, a thermometer or eye coverings.

Plan of Correction

Accept ([REDACTED] - 10/21/2025)

The First Aid Kit in the first floor main kitchen is for Employees only and is affixed to the wall. On 9/12/25, the Dining Manager labelled the Kitchen First Aid Kit for employees only. Tweezers, a thermometer, and eye coverings were added to the Kitchen First Aid Kit. There are first kits at the first floor Front Receptionist's Desk and at the PC 2nd Floor Nurses' Station for Personal Care Residents which contain all the requirements of 96a. PCHA will do quarterly audits to ensure that the Personal Care First Aid kits meet the requirements of 96a. The audit results will be reviewed/evaluated in the monthly Quality Management Team meeting and quarterly Quality Assurance meeting which includes Personal Care Administrator and Executive Director.

The Start date of the quarterly audits is 10/15/25. The next Quality Assurance meeting is scheduled for 10/16/25.

The next QMT meeting is scheduled for 11/13/25. The PCHA is responsible for presenting the audit results at both meetings.

Licensee's Proposed Overall Completion Date: 10/16/2025

96a - First Aid Kit (continued)

Implemented (█) - 01/28/2026)

124 - Notice to Fire Department

5. Requirements

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction

Accept (█) - 10/21/2025)

The January 2025 letter to the local fire department did not have the 9/8/25 list of Residents who needed assistance with evacuation. On 9/9/25, PCHA revised the letter to the local fire department to state that, "A list of Residents with their apartment numbers who need total assistance with evacuation is available at the second floor nurses' station". The letter was mailed to the local fire marshal. On an ongoing basis, the PCHA will ensure the annual fire safety letter is written to comply with Regulation 124.

During the survey, the LR did not dispute that the 2025 annual fire safety letter was sent to the local fire department in the appropriate time frame. The LR said the violation was because the letter was not correct because it did not have the 9/8/25 (date of survey) list of Residents who needed assistance with evacuation. The LR suggested that PCHA revise the letter to state, "A list of Residents with their apartment numbers who need total assistance with evacuation is available at the second floor nurses' station"; which the PCHA did on 9/9/25.

On an annual basis, the PCHA schedules the date on █ Outlook Calendar (this year the date is 12/9/25) to prepare the Annual Fire Safety Letter. The PCHA schedules a date (on █ Outlook Calendar) to email the Annual Fire Safety Letter to the local fire department (this year's date is 12/29/25). If the local fire department does not acknowledge receipt of the letter to the local fire department by 1/5/25, the PCHA will call the local fire department and document the acknowledgement. At the January QMT meeting, the PCHA will report that the status of the Annual Fire Safety Letter. Any issues with the letter, will be reviewed/evaluated by the PCHA and the Executive Director. The PCHA and the Executive Director will create corrective actions and the PCHA will implement the corrective actions.

Licensee's Proposed Overall Completion Date: 10/11/2025

Implemented (█) - 01/28/2026)

125a - Combustible Storage

6. Requirements

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On █ at approximately 1:10pm, there were two containers of 404A refrigerant with a warning label reading "Extremely flammable gas. Contains gas under pressure; may explode if heated" in the home's boiler room on the 9th floor.

Plan of Correction

Accept (█) - 10/21/2025)

Items were immediately removed to outside storage. Signs to be placed in boiler room stating, "Storage of any combustible items prohibited". Daily inspection of area to be placed in TELS Maintenance program by the Director

125a - Combustible Storage (continued)

of Facility Operations and documented each day by Maintenance staff. Director of Facility Operations to monitor daily reports and review during monthly Safety Committee meetings and quarterly Quality Assurance meeting which includes Personal Care Administrator and Executive Director.

The Director of Facility Operations placed the signs on 10/7/25. Daily inspection of area was placed in TELS Maintenance program by the Director of Facility Operations with a start date of 10/6/2023, and documented each day by Maintenance Supervisor. Director of Facility Operations to monitor daily reports and present/review during monthly Safety Committee meetings and quarterly Quality Assurance meetings, starting on 10/16/2025, which includes Personal Care Administrator and Executive Director.

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented [REDACTED] - 01/28/2026)

132g - Fire Drills Days/Times

7. Requirements

2600.

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

Description of Violation

The home routinely holds fire drills on Tuesdays and Thursdays as evidenced by the following drills:

- Tuesday [REDACTED] - 11:00am
- Thursday [REDACTED] - 2:30am
- Tuesday [REDACTED] 9:10pm
- Thursday [REDACTED] - 8:00am
- Tuesday [REDACTED] - 1:30am

Plan of Correction

Accepted [REDACTED] - 10/21/2025)

On 9/10/25. our fire safety company, Crocker Fire Safety Corporation, was informed of 132g. On 9/15/25, Crocker Fire Safety Corporation acknowledged in writing that they will hold fire drills on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low. After each Fire Drill, the Director of Facility Operations will give the PCHA the Record of Fire Drills to ensure compliance with 132g. The audit results will be reviewed/evaluated in the monthly Quality Management Team meeting and quarterly Quality Assurance meeting which includes Personal Care Administrator and Executive Director.

On 9/10/25. our fire safety company, Crocker Fire Safety Corporation, was informed of 132g, by Director of Facility Operations. On 9/15/25, Crocker Fire Safety Corporation acknowledged in writing that they will hold fire drills on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low. After each Fire Drill, the Director of Facility Operations will give the PCHA the Record of Fire Drills to ensure compliance with 132g. The audit results will be reviewed/evaluated in the monthly Quality Management Team meeting and quarterly Quality Assurance meeting, starting on 10/16/2025, which includes Personal Care Administrator and Executive Director.

132g - Fire Drills Days/Times (continued)

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented (████) - 01/28/2026)

132h - Designated Meeting Place

8. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During on site interviews with the Department on █████ several residents that reside outside of the primary personal care floors two and three, stated that they were not checked on during the fire drills held at the home and were not advised to evacuate while living on the higher floors.

Plan of Correction

Accept (████) - 10/21/2025)

On 9/10/25, Residents on the high floors were re-educated on the correct evacuation procedures during fire drills and emergencies. The Residents acknowledged understanding. During fire drills and emergencies, the Security Guard will go to the Residents on the higher floors to ensure that they evacuate. This process was followed during the 9/30/25 fire drill. Fire Drills are reviewed/evaluated at the quarterly Quality Assurance meeting which includes Personal Care Administrator and Executive Director.

The PCHA re-educated the residents. The next Quality Assurance meeting is 10/16/25.

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented (████) 01/28/2026)

141b1 - Annual Medical Evaluation

9. Requirements

2600.

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

Description of Violation

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

Plan of Correction

Accept (████) - 10/21/2025)

The Medical Records Coordinator is responsible for ensuring Resident's Medical Evaluations are completed annually. The Medical Records Coordinator uses a tracker for the due dates of the Medical Evaluations. On a monthly basis, PCHA and Medical Records Coordinator will audit the Medical Evaluations due dates for the upcoming 6 weeks to ensure that Residents have appointments scheduled. The audit results will be reviewed/evaluated in the monthly Quality Management Team meeting.

All records were reviewed to ensure compliance by the Medical Records Coordinator on 9/10/25. The Medical Records Coordinator started the audits on 10/6/25. The date of the next QMT is 11/13/25.

Licensee's Proposed Overall Completion Date: 10/27/2025

Implemented (████) - 01/28/2026)

183e - Storing Medications

10. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [REDACTED] at 9:57am, a clear, oblong pill was observed loose in the second-floor medication cart.

On [REDACTED] the following medication cards were observed to have a punctured blister foil with the medication still present in the spot- exposing it to contamination or improper sanitation:

- [REDACTED]
- [REDACTED]
- [REDACTED]

Plan of Correction

Accept [REDACTED] - 10/21/2025)

Between 9/11/25 and 9/13/25, all Personal Care Staff were trained on Regulation 2600 183e. All staff acknowledged understanding. On 9/10/25, all Residents' medications were checked for issues related to contamination or improper sanitation. The Medical Records Coordinator will audit the Residents' medications for compliance with Regulation 183e on a monthly basis. Any medications that are not in compliance with Regulation 183e will be properly disposed of. The audit results will be reviewed/evaluated in the monthly Quality Management Team meeting and quarterly Quality Assurance meeting which includes Personal Care Administrator and Executive Director.

The PCHA and the LPNs trained the PC staff. The Lead Dayshift Med Tech audited the medications on 9/10/25. The Medical Records Coordinator will do monthly audits starting 10/12/25. The PCHA will review the audit results. The PCHA will present the Audit Results at the quarterly Quality Assurance meetings. The next Quality Assurance Meeting is scheduled for 10/16/25.

Licensee's Proposed Overall Completion Date: 10/17/2025

Implemented [REDACTED] - 01/28/2026)

184b - Labeling OTC/CAM

11. Requirements

2600.

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

Description of Violation

On [REDACTED], present in the home's medication cart was a tube of [REDACTED], a bottle of [REDACTED] a bottle of [REDACTED] and a bottle of [REDACTED]; not labeled with a resident's name or room number.

Plan of Correction

Accept [REDACTED] 10/21/2025)

Between 9/11/25 and 9/13/25, all Personal Care Staff were trained on Regulation 184b. All staff acknowledged understanding. On 9/10/25, all Residents' medications were checked for issues related to contamination or

184b - Labeling OTC/CAM (continued)

improper sanitation. The Medical Records Coordinator will do monthly audits on Residents' medications for compliance with Regulation 184b. Any medications that are not in compliance with Regulation 184b will be properly disposed of. The audit results will be reviewed/evaluated in the monthly Quality Management Team meeting and quarterly Quality Assurance meeting which includes Personal Care Administrator and Executive Director. The PCHA and the LPNs trained the PC Staff. The Lead Dayshift Med Tech audited the current medications. The start date of the monthly audits is 10/12/25. The PCHA will present the audit results at the next Quality Assurance Meeting which is scheduled for 10/16/25.

Licensee's Proposed Overall Completion Date: 10/27/2025

Implemented [redacted] - 01/28/2026)

184c - Sample Prescription Meds.

12. Requirements

2600.

184.c. Sample prescription medications shall have written instructions from the prescriber that include the components specified in subsection (a).

Description of Violation

Sample [redacted] belonging to resident [redacted] was in the home's medication cart. The labels for this sample did not include written instructions from the provider to include the prescribed dosage and instructions for administration.

Plan of Correction

Accept [redacted] - 10/21/2025)

On 9/9/2025, Resident [redacted] Sample [redacted] was labelled with the prescriber's written instructions; the resident's name, the name of the medication, the date the prescription was issued, the prescribed dosage and instructions for administration, and the name and title of the prescriber. The Medical Records Coordinator will do monthly audits on Residents' medications for compliance with Regulation 184bc. Any medications that are not in compliance with Regulation 184c will be properly disposed of. The audit results will be reviewed/evaluated in the monthly Quality Management Team meeting and quarterly Quality Assurance meeting which includes Personal Care Administrator and Executive Director.

The Lead Dayshift Med Tech labeled the medication. The start date of the monthly audits is 10/12/25. The PCHA will present the audit results at the Quality Assurance Meeting; the next meeting is 10/16/25. The PCHA will present the audit results at the monthly QMT; the next meeting is 11/13/25.

Licensee's Proposed Overall Completion Date: 10/27/2025

Implemented [redacted] - 01/28/2026)

185a - Implement Storage Procedures

13. 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] - Inject as per sliding scale (if [redacted]) subcutaneously two times a day for DM. Notify MD for BS <70 or >400. On the following dates, readings were entered on Resident [redacted]'s medication administration record;

185a - Implement Storage Procedures (continued)

however, no readings were found in Resident [REDACTED]'s glucometer.

- [REDACTED]
- [REDACTED]
- [REDACTED]

Plan of Correction

Accept [REDACTED] - 10/21/2025)

On 10/2/25, the PC Staff was trained Regulation 185a and proper use of Smart Meter iGlucose Plus device. Effective 10/3/25, each Resident, who has orders for blood sugar testing, has a Smart Meter iGlucose Plus device assigned to them. The PC staff will take the Residents blood sugar with their individual device and the device will automatically record the Resident's blood sugar number directly into the Resident's individual EMAR.

The PCHA and the LPNs trained the PC Staff. After each Blood Sugar reading is input into the EMAR, the Med Tech or the LPN will verify with another Med Tech or the LPN that the glucometer meter reading matches the EMAR blood sugar reading. If the readings don't match; the first Med Tech or LPN will correct the reading immediately on the EMAR (and input the correct reading on the glucometer into the EMAR). The Lead Dayshift Med Tech will do weekly audits comparing the glucometer meter reading to the EMAR blood sugar reading. Weekly, the Lead Dayshift Med Tech will report the Audit Results to the PCHA. The PCHA will report the audit results at the monthly QMT (next meeting is 11/13/25). The QMT will review/evaluate and will decide on corrective actions. The PCHA will implement the corrective actions.

Licensee's Proposed Overall Completion Date: 10/27/2025

Implemented [REDACTED] - 01/28/2026)

225a - Assessment 15 Days

14. Requirements

2600.

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

Description of Violation

Resident [REDACTED]'s medical evaluation dated [REDACTED] states [REDACTED] uses a rolling walker or wheelchair for assistance with ambulation; however, Resident [REDACTED]'s support plan dated [REDACTED] assesses the resident as independent with ambulation.

Plan of Correction

Accept [REDACTED] - 10/21/2025)

On 9/12/25, Resident [REDACTED]'s RASP was updated with Resident using a rolling walker or a wheelchair for ambulation. During September 2025, the Medical Records Coordinator reviewed all Residents' RASPs to ensure that they were correct. The Medical Records Coordinator will do monthly audits of Residents' RASPs to ensure compliance with Regulation 225a. Any incorrect information will be immediately corrected by the Medical Records Coordinator. The audit results will be reviewed/evaluated in the monthly Quality Management Team meetings.

The Medical Records Coordinator updated the RASP. The start date of the monthly audits was 10/6/25. The next QMT meeting is 11/13/25. The PCHA will present the audit results at the QMT meetings. The QMT will review/evaluate and will decide on corrective actions. The PCHA will implement the corrective actions.

Licensee's Proposed Overall Completion Date: 10/27/2025

225a Assessment 15 Days (*continued*)

Implemented [REDACTED] - 01/28/2026)