



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ABODE CARE OF MONROEVILLE LLC**
LEGAL ENTITY

To operate **ABODE CARE OF MONROEVILLE**
NAME OF FACILITY OR AGENCY

Located at **2560 STROSCHEIN ROAD, MONROEVILLE, PA 15146**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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

The total number of persons which may be cared for at one time may not exceed **66**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: _____

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

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

and shall remain in effect from **December 19, 2025** until **June 19, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **451193**

Janette Biderup
ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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



Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 19, 2025

[REDACTED]
Abode Care of Monroeville LLC
2560 Stroschein Road
Monroeville, Pennsylvania 15146

RE: Abode Care of Monroeville
License/COC #: 451193

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on June 16, 2025, June 17, 2025, July 24, 2025, July 28, 2025, July 29, 2025, and September 15, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a THIRD PROVISIONAL license to operate the above facility. A THIRD PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your THIRD PROVISIONAL license is enclosed and is valid from DECEMBER 19, 2025 to JUNE 19, 2026.

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

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

| 55 Pa. Code Chapter 2600 | Class of Violation | Census at Inspection | Fine Per resident X Per day | Calculated Fine = Per day | Mandated Correction Date (to avoid Fine) |
|-----------------------------|--------------------------|-------------------------|-----------------------------------|---------------------------------|--|
| Section: | | | | | |
| 54(a) | III | 36 | \$3 | \$108 | 15 calendar days from mailing date of this letter |
| 65(f) | III | 36 | \$3 | \$108 | 15 calendar days from mailing date of this letter |
| 65(g) | III | 36 | \$3 | \$108 | 15 calendar days from mailing date of this letter |

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

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

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


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

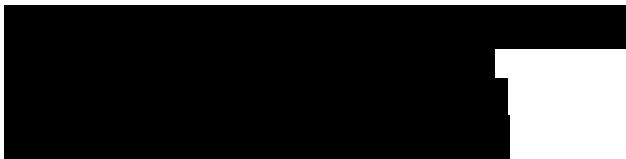
This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

A handwritten signature in black ink that reads "Juliet Marsala". The signature is written in a cursive, flowing style.

Juliet Marsala
Deputy Secretary
Office of Long-term Living

cc:



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

Facility Information

Name: *ABODE CARE OF MONROEVILLE* License #: *45119* License Expiration: *11/14/2025*
Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA 15146*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED]

Legal Entity

Name: *ABODE CARE OF MONROEVILLE LLC*
Address: *2560 STROSCHEIN ROAD, MONROEVILLE, PA, 15146*
Phone: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *6/4/2012* Issued by *Municipality of Monroeville*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *61* Waking Staff: *46*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *06/17/2025*

Inspection Dates and Department Representative

06/16/2025 - On-Site: [REDACTED]
06/17/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* Residents Served: *35*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *34*
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *26* Have Physical Disability: *1*

Inspections / Reviews

06/16/2025 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/25/2025*

Inspections / Reviews (*continued*)

08/05/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/15/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/11/2025

09/09/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/15/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission

Follow-Up Date: 09/15/2025

10/30/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/15/2025

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

23a - Activities of Daily Living Assistance

1. Requirements

2600.

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

Description of Violation

The assessment and support plan for resident #1, dated [redacted]/25, indicate the resident needs total physical assistance with transferring and to meet this need, the home will provide 2-person assistance with transferring using a Hoyer lift. On 6/2/25 at 7:30 p.m., only one staff person, staff person A, transferred the resident using the Hoyer lift. During this transfer, resident #1's calf came in contact with Hoyer lift, and tore the resident's skin, which required 4 stitches.

Plan of Correction

Accept [redacted] - 09/09/2025)

On 06/02/25 immediately following the incident the staff person responsible was counselled by the Executive Director. On 06/02/25 the Executive Director scheduled a training for all staff on proper use of Hoyer lifts and adherence to 2600.23.a. The Hoyer training/in-service with demonstration was given to staff on 6/18/25 by [redacted]. Two sessions were provided by [redacted] in order to cover all shifts at the facility. On 06/18/25 the Executive Director completed oral training with the staff regarding 2600.23a in conjunction with the Hoyer lift training. All training records will be kept in accordance with regulation on site and the Administrator will be responsible for ongoing compliance of maintaining all training records. Moving forward all direct care staff will receive Hoyer lift training and training regarding adherence to the resident care plans upon new hire training and annually thereafter by the Director of Wellness or Designee to ensure proper adherence to the resident's support plan. As of 8/05/2025 The Executive Director, Director of Wellness or designee will initiate hoyer lift competency observation for each direct care employee. These observations will be done bi weekly for the first 30 days with all direct care employees and new direct care staff. Thereafter the training and competency observation will be held on a quarterly basis. Dec 2025 will commence the first quarterly training and competency observation held by The Executive Director. Director of Wellness or designee

Licensee's Proposed Overall Completion Date: 09/05/2025

Not Implemented [redacted] - 10/28/2025)

85a - Sanitary Conditions

2. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

Throughout the day on 6/17/25, there were no paper towels, mechanical air blower, individual cloth towels or other means of safe hand drying in the main common bathroom.

Plan of Correction

Accept [redacted] - 08/05/2025)

On 06/17/25 following the inspection the Houskeeper replaced the automatic paper towel dispenser at the instruction and follow up of the Executive Director. On 06/18/25 the Executive Director re-educated the housekeeping staff on this regulation and put a daily checklist together for the housekeeping department to follow to ensure that regulation 2600.85.a is maintained. The housekeeping staff and the Executive Director will be responsible for ongoing compliance.

Proposed Overall Completion Date: 07/25/2025

85a - Sanitary Conditions *(continued)*

Licensee's Proposed Overall Completion Date: 07/25/2025

Not Implemented [REDACTED] - 10/28/2025)

187d - Follow Prescriber's Orders

3. Requirements

2600.

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

Description of Violation

Resident #2 did not receive multiple medications because they were not available in the home on the following dates and times, to include:

- Baclofen 10mg on 6/15/25 at 9:00 p.m., 6/16/25 at 8:00 a.m., 9:00 p.m.
- Duloxetine 30mg, 1 tablet on 6/16/25 and 6/17/25 at 8:00 a.m.

REPEAT VIOLATION: 1/15/25

Plan of Correction

Accepted [REDACTED] 08/05/2025)

On 06/16/25 while inspector on site the Executive Director provided receipts to the inspectors that demonstrated that the facility had requested refills for the mentioned medications. There were repeated attempts to contact the physician by both fax and phone. On 06/18/25 the orders were filled. On 06/18/25 Following the inspection the Executive Director, re-educated the Medtechs and Assistance Wellness Director on regulation 2600.187d. On 06/16/25 the Regional Director counselled the Executive Director on 2600.187 and 2600.16 reporting of medication error for a missed medication. Moving forward the Executive Director and Director of Wellness will be responsible for ongoing compliance to ensure adherence to 2600.187d.

Licensee's Proposed Overall Completion Date: 07/25/2025

Not Implemented [REDACTED] - 10/28/2025)

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

Facility Information

Name: *ABODE CARE OF MONROEVILLE* License #: *45119* License Expiration: *11/14/2025*
Address: *2560 STROSCHHEIN ROAD, MONROEVILLE, PA 15146*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED]

Legal Entity

Name: *ABODE CARE OF MONROEVILLE LLC*
Address: *2560 STROSCHHEIN ROAD, MONROEVILLE, PA, 15146*
Phone: [REDACTED]

Certificate(s) of Occupancy

Type: *1-2* Date: *06/04/2012* Issued By: *Municipality of Monroeville*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *64* Waking Staff: *48*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint, Provisional, Incident* Exit Conference Date: *07/29/2025*

Inspection Dates and Department Representative

07/24/2025 - On-Site: [REDACTED]
07/28/2025 - On-Site: [REDACTED]
07/29/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* Residents Served: *38*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *37*
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *26* Have Physical Disability: *0*

Inspections / Reviews

07/24/2025 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/06/2025*

09/15/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *09/06/2025*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/19/2025*

10/01/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: *09/19/2025*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *10/03/2025*

10/30/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: *10/07/2025*
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

- 1. Agents of the Department.

Description of Violation

On 7/24/2025 at 12:34 pm, an agent of the Department requested access to staff records for staff person A and staff person B, [REDACTED]. The records were not provided to the Department.

Plan of Correction

Accepted [REDACTED] - 10/01/2025)

On 07/25/25 Immediately following the inspection the Regional Director of Operations reviewed and educated the Executive Director 2600.5.a.

On 08/12/25 and 08/13/25 an Audit on all employee and resident records was conducted by a peer Administrator as part of a Quality Assurance Measure to ensure all records are complete and accessible for agents of the department upon demand.

The Executive Director will review this regulation with the DOW, Lead Med Tech to be aware of how to extract the information required to assist in the gathering of the information needed.

Moving forward, the Executive Director will be responsible to ensure that ongoing compliance is maintained and that all records are provided to the department as per 2600.5a.

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

Implemented [REDACTED] - 10/28/2025)

17 - Record Confidentiality

2. 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 7/24/2025 at 9:05 am there were multiple unlocked, unattended, and accessible resident records in the conference room to include:

- * Preadmission screen, dated [REDACTED]/2023, for resident #1
- * Medication record for resident #2 dated from 7/12/2025 -- 7/15/2025
- * Medical evaluation, assessment and support plan for resident #3

Repeat Violation 5/15/25 et al; 1/15/25 et al

Plan of Correction

Accepted [REDACTED] - 10/01/2025)

On 07/24/25 the previous administrator left confidential records in the conference room which was not secure.

Previous administrator immediately removed the records upon inspectors' arrival. On [REDACTED]/25 the administrator was [REDACTED] from the facility.

17 - Record Confidentiality (continued)

Executive Director will educate all staff on this regulation and perform daily walkthroughs moving forward looking for any confidentiality concerns starting upon DHS approved report. This will be reviewed at the Oct 1st, 2025 QA meeting and the walkthroughs will be done for 3 months.

Current administrator/designee understands the 2600.17 requirements and will not leave items unattended in the future. on 07/27/25 Both the administrator/designee have reviewed the policy on confidentiality.

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

Implemented [REDACTED] - 10/28/2025)

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 Standard Act, enacted 9/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. If the carbon monoxide alarm operates by a battery, the battery may not be removed for any length of time beyond that necessary to change the battery. The battery must be labeled with the date of installation and replaced at least annually.

On 7/24/2025 at 10:35 am, the built-in carbon monoxide detector in the kitchen was less than 15 feet from the gas stove. There was also a battery operated carbon monoxide detector in the kitchen which was at least 15 feet away; however, it was inoperable.

Repeat Violation: 1/15/25 et al

Plan of Correction

Accept [REDACTED] - 09/09/2025)

On 7/24/25 the facility Carbon Monoxide detector in the kitchen was less than 15 feet from the gas stove. There was also a battery-operated carbon monoxide detector in the kitchen which was at least 15 feet away. This was, however, inoperable.

On July 25, 2025, upon notification that the facility's Carbon monoxide Detector was positioned incorrectly for close proximity to facility stove. The Carbon Monoxide detector was positioned within the correct limit according to this regulation by our maintenance coordinator. The maintenance coordinator checked the detector to ensure it was in working condition. As of 07/25/25 the Maintenance Coordinator/designee will perform daily walkthroughs to test the detector and ensure it meets the safety requirements.

Upon receiving future notifications from Federal, State and Local laws, ordinances and regulations the administrator and/or the maintenance person will coordinate efforts to review and implement any such policy changes.

Licensee's Proposed Overall Completion Date: 09/04/2025

Implemented [REDACTED] - 10/28/2025)

25a - Written Contract and Review

4. Requirements

2600.

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

Description of Violation

Resident #4, admitted [redacted]/2022, does not have a resident-home contract completed.

Repeat Violation 1/15/25 et al

Plan of Correction

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

Resident #4 admitted on [redacted]/2022 was missing signed contract. Residents contract was located, reviewed and is complete, it was not located during the inspection. On 08/12/25 and 08/13/25 an audit on all resident records was completed to ensure 2600.25a .

On 8/12/25 and 08/13/25, a resident file audit was completed to ensure all contracts were in files and signed.

Moving forward, as of 08/01/25 a new procedure was put into place that will require the administrator to audit all new admission records to ensure contracts and other required items are in the residents in its entirety shall kept in the resident's file.

Licensee's Proposed Overall Completion Date: 09/04/2025

Not Implemented ([redacted] - 10/29/2025)

25b - Contract Signatures

5. 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 for resident #5, dated [redacted]/2025, was not signed or dated by the resident, payer or the Administrator.

25b - Contract Signatures (continued)

The resident-home contract for resident #6, dated [REDACTED]/2025, was not signed or dated by the resident, payer or the Administrator.

The resident-home contract for resident #7, dated [REDACTED]/2025, was not signed or dated by the Administrator.

Repeat Violation: 9/20/24 et al

Plan of Correction

Accept [REDACTED] - 09/09/2025)

The resident home contract for resident #5 dated [REDACTED]/25 and resident #6 dated [REDACTED]/25 was not signed or dated by the resident, payer or the administrator.

The resident home contract for resident #7 dated [REDACTED]/25 was not signed or dated by the administrator. These contracts were not available at the time of inspection. On 07/26/25 The contracts for residents #5, #6 and #7 were located and completed.

On 8/12/25 and 08/13/25, a resident file audit was completed to ensure all contracts were in files and signed.

Moving forward, as of 08/01/25 a new procedure was put into place that will require the administrator to audit all new admission records to ensure contracts and other required items are in the residents in its entirety shall kept in the resident's file.

Licensee's Proposed Overall Completion Date: 09/04/2025

Not Implemented [REDACTED] - 10/29/2025)

25c6 - Refunds

6. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

- 6. The conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death.

Description of Violation

The resident-home contract for resident #5, dated [REDACTED]/2025, does not specify the conditions under which refunds will be made, including the refund of admissions fees and refunds upon the resident's death.

The resident-home contract for resident #7, dated [REDACTED]/2025, does not specify the conditions under which refunds will be made, including the refund of admissions fees and refunds upon the resident's death.

25c6 - Refunds (continued)

Plan of Correction

Accept [redacted] - 10/01/2025)

The resident home contract for resident #5 dated [redacted] 25 and resident #7 dated [redacted] /25 does not specify the conditions under which refunds will be made, including the refund of admissions fees and refunds upon the resident's death.

The facility has updated and implemented a revised resident contract that was implemented on August 1, 2025, to include items under 2600.25.c. Facility will immediately use the new contract which outlines specifically resident refunds in section D of the contract.

Facility will keep the addendum with the original contract with the resident's contract in the original file.

By 09/12/25 the Administrator will send out a notice to all residents and residents designated persons with the revised contract information that includes our existing policy that specifies the conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death to ensure all residents have received this information.

Moving forward the Administrator and Marketing Director will be responsible to ensure the revised contract is used for all new admissions.

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

Not Implemented [redacted] - 10/29/2025)

25c12 - Bed Hold

7. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

- 12. Charges to the resident for holding a bed during hospitalization or other extended absence from the home.

Description of Violation

The resident-home contract for resident #5, dated [redacted] /2025, does not specify the charges to the resident, if any, for holding a bed during hospitalization or other extended absence from the home.

The resident-home contract for resident #7, dated [redacted] /2025, does not specify the charges to the resident, if any, for holding a bed during hospitalization or other extended absence from the home.

Plan of Correction

Accept [redacted] - 10/01/2025)

The resident's home contract for resident #5 dated [redacted] /25 does not specify the charges to the resident, if any, for holding a bed during hospitalization or other extended absence from the home. The facility has updated and implemented a revised resident contract that was implemented on August 1, 2025, to include items under 2600.25.c. Facility will immediately use the new contract which outlines specifically resident refunds in section D of the contract. By 09/12/25 the Administrator will send out a notice to all residents and residents designated persons with the revised contract information that includes our existing policy that specifies the conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death to ensure all residents have received this information.

Facility will keep the addendum with the original contract with the resident's contract in the original file.

Moving forward the Administrator and Marketing Director will be responsible to ensure the revised contract is used

25c12 - Bed Hold (continued)

for all new admissions.

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

Not Implemented [REDACTED] - 10/29/2025)

54a - Direct Care Staff**8. Requirements**

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

The following direct care staff persons do not have a high school diplomas, GED, or active registry status on the Pennsylvania nurse aide registry:

- Staff person D
- Staff person E
- Staff person G

Repeat Violation: 1/15/25 et al

Plan of Correction

Accept [REDACTED] - 10/01/2025)

The following direct care staff persons do not have a high school diplomas, GED, or active registry status on the PA nurse aide registry:

Staff Person D

Staff Person E

Staff Person G

On 7/25/25 staff person D, E and G provided their high school diplomas, GED or active registry status on the PA nurse aide registry. The Wellness Director assigned supervised training for staff person D, E and G until the documents were collected and entered into their employee personnel files.

On 08/12/25 and 08/13/25 and audit was completed on all employee records to ensure 2600.54.a. as well of other areas of compliance are met. The administrator will review all new hire training and qualifications to ensure staff does not provide unsupervised care.

On 08/13/25 the Regional Director met with the Administrator and Director of Wellness to review regulation 2600.54.a. and educated both on the company hiring process that requires the administrator or designee to ensure

54a - Direct Care Staff (continued)

direct care staff persons qualification documents are obtained prior to their initial hire date in order to ensure ongoing compliance. The Administrator and Director of Wellness will be responsible for ongoing compliance.

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

Not Implemented [REDACTED] - 10/28/2025)

57d - Waking Hours

9. 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 7/26/2025,, there were 38 residents in the home, with 26 residents having a mobility need, requiring a minimum of 48 hours of direct care staffing to be provided during waking hours. However, on this date, only 45.5 hours of direct care staffing was provided.

Plan of Correction

Accept [REDACTED] - 09/09/2025)

On 7/26/25 there were 38 residents in the home, with 26 residents having a mobility need, requiring a minimum of 48 hours of direct care staffing to be provided during the waking hours. However, on this date, only 45.5 hours of direct care staffing was provided.

On 07/26/25 The administrator had reviewed the regulation specified in subsections (b, c) for awake hours.

On 07/26/25 the schedule was adjusted to meet this regulation. As of 07/6/25 the Administrator will audit the following weeks schedule on a weekly basis with the Wellness Director to ensure staffing hours meet the regulation.

Licensee's Proposed Overall Completion Date: 09/04/2025

Implemented [REDACTED] 10/29/2025)

65d - Initial Direct Care Training

10. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person F, hired on [REDACTED]/2025, began providing unsupervised ADL services on 7/14/2025. However, the staff person did not complete the Department-approved direct care training course and competency test.

Direct care staff person G hired on [REDACTED] 2025, began providing unsupervised ADL services on 7/15/2025. However, the staff person did not complete the Department-approved direct care training course and competency test.

65d - Initial Direct Care Training (continued)

Plan of Correction

Accept [redacted] - 09/09/2025)

On 07/29/25 staff person f was placed on an immediate plan of supervision by the Administrator until completion of the direct care worker course on 08/01/25. Although, staff person F had completed the Direct Care worker course the records were not located to staff person F retook the course.

During the inspection staff person G's direct care certificate was not located. However, it was located immediately following the inspection and the certificate date is 06/29/23.

On 08/12/25 and 08/13/25 as part of Quality Measure Process all resident and employee records were audited by the facility Home Office QA team member.

During the week of 07/29/25 the new administrator was educated on the communities hiring process that includes what records need to be present prior to direct care workers providing unsupervised ADL services. This education was provided by the regional director. Records of this education will be kept in the administrators record.

Moving forward the Administrator will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: 09/05/2025

Not Implemented [redacted] - 10/28/2025)

65e - 12 Hours Annual Training

11. Requirements

2600.

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

Description of Violation

The following staff persons completed zero hours of annual training during the 2024 training year.

- Direct care staff person C, hired [redacted]/2022
- Direct care staff person H, hired [redacted]/2022
- Direct care staff person I, hired [redacted]/2023

Plan of Correction

Accept [redacted] - 10/01/2025)

During the inspection staff person, I had not worked at the community and staff person C and H were suspended for unrelated reasons. Staff person C and H had ultimately been terminated and had never returned to the community to complete training. On 08/12/25 and 08/13/25 an audit on all employee records was conducted by a home office Quality Assurance Team Member. All training records were reviewed, and all areas of deficiency were addressed. The administrator/designee will review staff training every quarter as part of the QA management review to ensure staff training is completed in a timely manner.

As of 08/29/25 the community contracted with Relias a training company to establish a program for new hire and annual training for all employees to ensure compliance with 2600.65. The Administrator will be responsible for ongoing compliance of all staff training.

Proposed Overall Completion Date: 09/19/2025

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

65e - 12 Hours Annual Training (continued)

Not Implemented (█) - 10/28/2025)

65f - Training Topics

12. 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.
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

The following staff persons did not receive training in any of the required topics in accordance with 65f during the 2024 training year:

- Direct care staff person C, hired █/2022
- Direct care staff person H, hired █/2022
- Direct care staff person I, hired █/2023

Repeat Violation: 1/15/25 et al

Plan of Correction

Accept (█) - 10/01/2025)

During the inspection staff person, I had not worked at the community and staff person C and H were suspended for unrelated reasons. Staff person C and H had ultimately been terminated and had never returned to the community to complete training. On 08/12/25 and 08/13/25 an audit on all employee records was conducted by a home office Quality Assurance Team Member. All training records were reviewed, and all areas of deficiency were addressed. The administrator/designee will review staff training every quarter as part of the QA management review to ensure staff training is completed in a timely manner.

As of 08/29/25 the community contracted with Relias a training company to establish a program for new hire and annual training for all employees to ensure compliance with 2600.65. The Administrator will be responsible for ongoing compliance of all staff training.

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

Not Implemented (█) - 10/28/2025)

65g - Annual Training Content

13. Requirements

2600.

65g - Annual Training Content (continued)

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
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.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

The following staff persons did not receive training in any of the required topics in accordance with 65g during the 2024 training year:

- Direct care staff person C, hired [REDACTED]/2022
- Direct care staff person H, hired [REDACTED]/2022
- Direct care staff person I, hired [REDACTED] 023

Repeat Violation: 1/15/25 et al

Plan of Correction

Accept [REDACTED] - 10/01/2025)

During the inspection staff person, I had not worked at the community and staff person C and H were suspended for unrelated reasons. Staff person C and H had ultimately been terminated and had never returned to the community to complete training. On 08/12/25 and 08/13/25 an audit on all employee records was conducted by a home office Quality Assurance Team Member.

The administrator/designee will review staff training every quarter as part of the QA management review to ensure staff training is completed in a timely manner.

All training records were reviewed, and all areas of deficiency were addressed. As of 08/29/25 the community contracted with Relias a training company to establish a program for new hire and annual training for all employees to ensure compliance with 2600.65. The Administrator will be responsible for ongoing compliance of all staff training.

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

Not Implemented [REDACTED] - 10/28/2025)

85a - Sanitary Conditions

14. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 7/24/2025 at 10:40 am, there was a red sticky substance spilled across the bottom shelf and down the front of the commercial refrigerator in the kitchen.

On 7/24/2025 at 10:50 am, there was a coating of built-up ice, food debris, and pieces of cardboard on the bottom of the large chest freezer in the food pantry.

85a - Sanitary Conditions (continued)

Plan of Correction

Accepted [redacted] - 09/09/2025)

On 7/24/25 Kitchen staff removed all items from this refrigerator and cleaned the red sticky substance away. On 07/25/25 the chest freezer was emptied, defrosted and cleaned out. On 07/26/25 the Kitchen staff was educated by the Executive Director on the 2600.85a. As of 08/01/25 a revised kitchen and pantry cleaning protocol was put into place to ensure regular and routine cleaning is completed to ensure sanitary conditions are maintained.

Licensee's Proposed Overall Completion Date: 09/05/2025

Not Implemented [redacted] - 10/28/2025)

85d - Trash Receptacles

15. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 7/24/2025 at 10:43 am, there was an uncovered, unattended trash can in the kitchen. The trash can was 1/2 full.

Repeat Violation: 1/15/25 et al

Plan of Correction

Accepted [redacted] - 09/09/2025)

On 07/24/25 a lid was placed on the uncovered trash can by the dining staff. On 07/26/26 The administrator reviewed this regulation with all kitchen staff who shall be responsible for ensuring ongoing compliance on a daily basis. As of 08/01/25 a revised kitchen and pantry cleaning protocol was put into place to ensure regular and routine cleaning is completed to ensure sanitary conditions are maintained that includes keeping trash receptacles covered. As of 08/04/25 the Administrator or designee will be responsible for daily walk through to the kitchen to ensure 2600.85d and all other areas of compliance are being met.

Licensee's Proposed Overall Completion Date: 09/05/2025

Implemented [redacted] 10/28/2025)

88a - Surfaces

16. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 7/24/2025 at 10:20 am, a strip of vinyl flooring was curling up in the hallway in front of the exit door at the end of hallway "A". This strip separated from the floor, posing a trip/fall hazard.

88a - Surfaces (continued)

Plan of Correction

Accept [redacted] - 09/09/2025)

On 7/24/25 a strip of vinyl flooring was curling up in the hallway in directly in the front of the exit door at the end of hallway A. Immediately the maintenance person glued and repaired the curling to allow a non-trip and non-fall hazard. On August 1, 2025 the administrator educated all staff persons to be aware of any safety issues and report them to the administrator/designee immediately. As of 8/4/25 the administrator/designee shall perform a daily walkthrough of the facility to ensure the safety of any hazards of floor, walls, windows, doors and other surfaces are clean and in good repair. This inspection of the facility will be daily for 4 weeks then monthly to ensure compliance and address any possible problems. Audits will be kept in the administrative office and be reviewed at the next quarterly QA meeting scheduled for October 1, 2025.

Licensee's Proposed Overall Completion Date: 09/05/2025

Implemented [redacted] - 10/28/2025)

89a - Water Pressure

17. Requirements

2600.

89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 7/29/2025 from 12:24 pm to 1:00 pm there was no hot water in the following bathroom sinks:

- * The temperature in the shared bathroom for rooms 201&202 and 205&206 measured 81.1 degrees Fahrenheit.
- * The temperature in the bathroom for rooms 107&108 and 111&112 measured 88.5 degrees Fahrenheit.
- * The temperature in resident #8's bathroom measured 90.1 degrees Fahrenheit.

Plan of Correction

Accept [redacted] - 10/01/2025)

On 8/1/25 maintenance coordinator adjusted the water tank for these rooms to ensure the water temperature was within the guidelines. As of 08/04/25 the Maintenance Coordinator will audit the water temperature in various areas of the facility daily for four weeks to ensure ongoing compliance of 2600.89a.

Audits will be kept in the administrative office and will be reviewed at the next QA meeting scheduled for October 1, 2025.

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

Implemented [redacted] - 10/28/2025)

95 - Furniture and Equipment

18. Requirements

2600.

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

Description of Violation

On 7/24/2025 at 10:50 am, the rubber gasket on the lid of the Frigidaire large chest freezer in the food pantry was loose and did not seal the freezer. In addition, the inside lid of the door was loose.

95 - Furniture and Equipment (continued)

Plan of Correction

Accept [redacted] - 09/09/2025)

Following the inspection, on 07/25/25 a new freezer was ordered, and the old freezer's use was discontinued. Delivery of the new freezer arrived on August 22, 2025. On 08/01/25, the Administrator re-educated the kitchen staff and all staff on reporting immediately and furniture or equipment that is not in good repair, clean or free of hazards. As of 8/4/25 the administrator/designee shall perform a daily walkthrough of the facility to ensure the safety of any hazards of floor, walls, windows, doors and other surfaces are clean and in good repair. This inspection of the facility will be daily for 4 weeks then monthly to ensure compliance and address any possible problems. Audits will be kept in the administrative office and be reviewed at the next quarterly QA meeting scheduled for October 1, 2025.

Licensee's Proposed Overall Completion Date: 09/05/2025

Implemented [redacted] - 10/28/2025)

100a - Exterior - Free of Hazards

19. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 7/24/2025 at 10:22 am, there were 5 wooden planks that were detached from the support beams under the deck on the emergency fire exit/ramp at the end of hallway "A".

On 7/24/2025 at 10:28 am, there were 2 screws protruding about 1 inch out of the railing to the left surrounding the back deck posing a skin tear hazard.

Plan of Correction

Accept [redacted] - 10/01/2025)

On 7/25/25 the maintenance coordinator removed safety concerns from the beams under the deck and replaced them with new screws which were tightened. Additionally, on 07/25/25 the Maintenance Coordinator walked the deck looking for any other safety concerns to ensure the deck was secure and safe. Maintenance Coordinator/designee will walk the exterior of the building at least monthly to ensure there is no safety concerns.

Documentation will be kept in the administrator office or in the maintenance department.

Audits will be reviewed on the next QA meeting scheduled for October 1, 2025. Audits will be kept in the administrator's office.

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

Implemented [redacted] - 10/28/2025)

101j7 - Lighting/Operable Lamp

20. Requirements

2600.

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

101j7 - Lighting/Operable Lamp (continued)

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 7/29/2025 there was no source of lighting that could be turned on/off from the bedside for the following residents at the following times:

- At 10:36 am, resident #9. The light switch for the built in wall light is approximately 4 feet from the bed.

- At 12:25 pm, resident #10. The light switch for the wall light mounted above the bed was behind the resident's headboard.

- At 12:58 pm, resident #8. The light switch for the wall mounted lamp was approximately 4 feet from the resident's bed and the lamp on the nightstand next to the bed had no light bulb.

Plan of Correction

Accepted [REDACTED] - 09/09/2025)

On 07/29/25 Immediately upon receipt of violation report, the Maintenance coordinator added bedside lighting to each resident's rooms. As of 08/04/25 the Administrator will conduct daily walkthroughs for 4 weeks to ensure 2600101j and other areas of compliance are met. Documentation of these records will be kept in the Administrators office and will be reviewed at the next quarterly Quality QA meeting scheduled for October 1, 2025. Lastly, on 08/22/25 the Administrator ordered touch lights to provide an alternative option for residents not preferring to have a lamp in order to ensure that an operable lamp or other source of lighting that can be turned on at bedside at all times. On 08/01/25 the Administrator held a training with all staff to educate them on reporting of any rooms that inoperable bedside lighting immediately, which includes burnt out lightbulbs or missing lighting. This education to all staff will also support the Administrator/designee to ensure going compliance.

Licensee's Proposed Overall Completion Date: 09/05/2025

Implemented [REDACTED] - 10/28/2025)

103e - Left Overs**21. Requirements**

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 7/24/2025 at 10:43 am, there was an open, unsealed and undated tray of California Rolls on the top shelf in the commercial refrigerator in the kitchen.

At 11:04 am, there were various 17.5-quart tubs of undated, unlabeled food on the shelves in the pantry.

At 11:06 am, there was a bag of macaroni and a bag of noodles that were opened and undated on the shelf in the pantry.

103e - Left Overs (continued)

Plan of Correction

Accept [redacted] - 10/01/2025)

On 07/24/25 disposed of the California rolls and open macaroni and bag of noodles. The sealed 17.5 tubs of food were dated and labeled.

On 07/26/25 the Administrator re-educated the kitchen staff on 2600.103.e

As of 08/01/25 the Administrator/designee will complete daily walk-through audits for 4 weeks and monthly monitoring to ensure ongoing compliance.

Documentation of these walk throughs will be kept in the Administrators office. This will be reviewed at the next Quality Review meeting scheduled for October 1, 2025

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

Implemented [redacted] - 10/28/2025)

103f - Refrigerator/Freezer Temps

22. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 7/24/2025 at 10:53 am the temperature in the large Frigidaire chest freezer was 30 degrees Fahrenheit.

The small chest freezer to the left of the larger chest freezer and the bread freezer did not have thermometers.

The bread freezer did not have a thermometer.

Repeat Violation 1/15/25 et al

Plan of Correction

Accept [redacted] - 10/01/2025)

On 07/25/25 the small chest freezer was emptied and put out of use due to violation 2600.95. Following the inspection, on 07/25/25 a new freezer was ordered, and the old freezer's use was discontinued. Delivery of the new freezer arrived on August 22, 2025. On 08/01/25, the Administrator re-educated the kitchen staff an on 2600.103f. On 07/25/25 thermometers were added to the operable freezers. As of 8/4/25 the administrator/designee shall perform a daily walkthrough of the facility and will audit for 4 weeks to ensure that 2600.103f is being met. This inspection of the facility will be daily for 4 weeks then monthly to ensure compliance and address any possible problems. Audits will be kept in the administrative office and be reviewed at the next quarterly QA meeting scheduled for October 1, 2025.

Facility purchased a new freezer and had the large chest freezer removed. All freezers and refrigerators have new thermometers installed and the administrator educated the kitchen staff to check and record temperatures on the data sheets. Administrator/designee will perform daily walk throughs to ensure temperatures are within the regulation and the data has been documented on the facility logs. Audits of daily/monthly inspections will be reviewed at the next quarterly QA meeting on October 1, 2025 which includes a review of all items specified in 2600.26b.

Documentation of audits will be kept in the administrator's office.

103f - Refrigerator/Freezer Temps (continued)

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

Implemented [REDACTED] 10/28/2025)

103g - Storing Food**23. Requirements**

2600.

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

Description of Violation

On 7/24/2025 at approximately 10:45 am, the following frozen food items were in the large Frigidaire chest freezer in the food pantry, opened, unsealed and undated:

- * A large box of 40 boneless 4 oz porkchops.
- * 2 large clear plastic bags of barbecued rib patties.

On 7/24/2025 at 11:00 am, there were 2 opened, unsealed and undated boxes of unbaked cookies in the upright freezer to the right of the chest freezer.

There was 1/2 of a bag of "Everything" bagels opened, unsealed and undated in the small bread freezer in the food pantry.

Plan of Correction

Accept [REDACTED] - 09/15/2025)

On 07/25/25 boneless porkchops and rib patties, bagels and cookies were disposed of following the inspection. On 08/01/25, the Administrator re-educated the kitchen staff on 2600.103 in its entirety. As of 8/4/25 the administrator/designee shall perform a daily walkthrough of the facility and will audit for 4 weeks to ensure that 2600.103 is being met. This inspection of the facility will be daily for 4 weeks then monthly to ensure compliance and address any possible problems. Audits will be kept in the administrative office and be reviewed at the next quarterly QA meeting scheduled for October 1, 2025.

Licensee's Proposed Overall Completion Date: 09/05/2025

Implemented [REDACTED] - 10/28/2025)

121a - Unobstructed Egress**24. Requirements**

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

121a - Unobstructed Egress (continued)

Description of Violation

On 7/24/2025, at approximately 11:45 am, the exit door from hallway "C", leading outside, required excessive force to open.

Plan of Correction

Accept (████) - 09/15/2025)

On 07/24/25 while inspectors on site the maintenance coordinator adjusted the exit door from hallway C leading outside to ease the opening and closing of this door. Administrator inspected the door and all other doors to ensure they are unlocked and unobstructed.

As of 08/04/25 the Administrator will begin daily rounding to include checking egresses for obstructions. These audits will be conducted by the administrator/designee and include a check of all hallways, doorways, passageways and egress routes from rooms and from the building to ensure they are unlocked and unobstructed. Audits will be kept in the Administrators office. At the next monthly staff meeting scheduled for 09/17/25 All staff persons will be educated that all stairways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. Documentation of the staff education shall be kept in accordance with 2600.65i.

Licensee's Proposed Overall Completion Date: 09/17/2025

Implemented (████) - 10/28/2025)

127a - Portable Space Heaters

25. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 7/28/2025, at 2:36 pm, resident #11 had a space heater plugged in and in use on the nightstand in █████ room.

Repeat Violation: 1/15/25 et al

Plan of Correction

Accept (████) - 09/15/2025)

On 7/28/25 the administrator removed the space heater and explained to the resident that it was unsafe and not permitted to have any kind of heat source in resident's rooms. Family was also notified on 07/28/25 by the administrator.

On 08/01/25 Administrator/designee reviewed this policy with the staff to make them aware of the regulation and to report any other heat sources that may be placed in the resident's room. By 09/15/25 the Administrator will send out a notice to all residents /designated persons regarding the prohibition of space heaters. As of 8/4/25 the administrator/designee shall perform a daily walkthrough of the facility and will audit for 4 weeks to ensure that 2600.103 is being met. This inspection of the facility will be daily for 4 weeks then monthly to ensure compliance and address any possible problems. Audits will be kept in the administrative office and be reviewed at the next quarterly QA meeting scheduled for October 1, 2025.

Licensee's Proposed Overall Completion Date: 09/15/2025

Implemented (████) - 10/29/2025)

132d - Evacuation

26. Requirements

2600.

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

Description of Violation

According to the home's fire safety inspection letter from a fire safety expert, dated [redacted]/2024, the home has 5 minutes to evacuate. However, on the following dates and times the home exceeded an evacuation time of 5 minutes:

- * 1/16/2025, 6 minutes 45 seconds
- * 2/12/2025, 5 minutes 12 seconds
- * 3/19/2025, 7 minutes 26 seconds

Repeat Violation: 1/15/25 et al

Plan of Correction

Accept [redacted] - 10/01/2025)

On 07/26/25 the Regional Director met with the Maintenance Coordinator on regulation 2600.132d and provided education to ensure that evacuation times are being met. Maintenance Coordinator has been instructed by the administrator to repeat the fire drill if the timed allotted has not been met. The documentation and results of the timed fire drill shall be on the correct form and reviewed monthly for 2 months with the administrator. The Regional Director also reviewed this with the new Administrator on 07/26/25, and he acknowledges understanding of this regulation and will oversee the fire drill for the next 2 months to ensure that evacuations are being completed within the allotted evacuation time frame.

The administrator will review the time limit on the fire drills to the whole staff upon the completion of the timed evacuation. The Administrator and Maintenance Coordinator will be responsible to ensure that monthly fire drills meet the expectations of the fire safety expert.

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

Not Implemented [redacted] - 10/28/2025)

132f - Alternate Exit Routes

27. Requirements

2600.

132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The front door was the only exit route used during the fire drills held from January to April 2025. The exit route used for the fire drills held in May, June and July 2025 all indicate "safe areas" were used for evacuation.

Plan of Correction

Accept [redacted] - 10/01/2025)

On 07/26/25 the Regional Director met with the Maintenance Coordinator on regulation 2600.132d and provided education to ensure that evacuation times are being met. Maintenance Coordinator has been instructed by the administrator to repeat the fire drill to accommodate the other approved safe zone exits. The documentation and results of the timed fire drill shall be on the correct form and reviewed monthly for 2 months with the administrator. The Regional Director also reviewed this with the new Administrator on 07/26/25, and [redacted] acknowledges

132f - Alternate Exit Routes (continued)

understanding of this regulation and will oversee the fire drill process to ensure that evacuations are being completed within the allotted evacuation time frame. The Administrator and Maintenance Coordinator will be responsible to ensure that monthly fire drills are meeting regulations and include the use of alternate exit routes. The staff will be educated on the need to alternate exits and location of each fire drill exercise. This regulation will be reviewed at the QA meetings quarterly meeting with all staff and will include a review of all items specified in 2600.26b.

Documentation will be kept in the maintenance area or in the administrator's office.

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

Not Implemented [REDACTED] - 10/28/2025)

141a - Medical Evaluation

28. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

The initial medical evaluation for resident #6, dated [REDACTED]/2025, did not include the license number of the medical professional who examined the resident or a medication regimen. Those sections of the form were blank.

The initial medical evaluation for resident #7, dated [REDACTED]/2025, did not include the license number of the medical professional who examined the resident. That section of the form was blank.

Repeat Violation: 1/15/2025 et al

Plan of Correction

Accept [REDACTED] - 10/01/2025)

On 07/29/25 Immediately, following inspection the administrator reviewed this requirement with the Director of Wellness and reached out to the medical providers to have the medical evaluations updated to include the license number on residents #6 and 7's medical evaluations. An audit was conducted on 08/12/25 and 08/13/25 of all resident records to address any deficient areas. All areas of deficiency have been addressed. Also, on 08/13/25 the Director of Wellness was trained on how to use the facilities system, Tabula PRO to track missing information and to pull reports in order to ensure ongoing compliance. Moving forward the Director of Wellness and Administrator will be responsible for ongoing compliance.

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

Not Implemented [REDACTED] - 10/29/2025)

141b1 - Annual Medical Evaluation

29. Requirements

2600.

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

Description of Violation

The medical evaluation for resident #12 is dated [REDACTED]/25 and signed by the physician and dated [REDACTED]/25; however, this medical evaluation form was not issued to facilities until June 2025.

141b1 - Annual Medical Evaluation (continued)

The medical evaluation for resident #4, dated [REDACTED]/2024, does not include the license number of the medical professional who examined the resident. This section of the form is blank.

Plan of Correction

Directed [REDACTED] - 10/01/2025)

Immediately, following inspection on 07/29/25 the administrator reviewed this requirement with the Director of Wellness and reached out to the medical providers to have the medical evaluations updated to include the license number on residents #4's medical evaluation. An audit was conducted on 08/12/25 and 08/13/25 by the Home Office QA Team member on all resident records to address any deficient areas. All areas of deficiency have been addressed since. Also, on 08/13/25 the Director of Wellness was trained on how to use the facilities system, Tabula PRO to track missing information as well as when annual medical evaluations are due and to pull reports in order to ensure ongoing compliance. Moving forward the Director of Wellness and Administrator will be responsible for ongoing compliance.

Wellness Director and Lead Med Tech was educated on this regulation and to ensure that all areas of the form is in compliance. This team will review all current medication evaluations weekly by reviewing 5 residents over the next 8 weeks to ensure all information is correct. Then we will pull 6 residents weekly for 3 months to ensure the audit is completed correctly to meet this regulation.

This regulation will be reviewed on our QA meeting scheduled on October 1, 2025. Audit results will be locked in the administrators office.

DIRECTED: Within 24 hours of receipt of the plan of correction - The administrator will ensure all staff are educated that documentation is to be dated on the actual date of completion and any changes are initialed and dated with the current date. - [REDACTED] 10/1/25

Directed Completion Date: 10/02/2025

Not Implemented [REDACTED] - 10/29/2025)

183d - Prescription Current

30. Requirements

2600.

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

Description of Violation

There is Melatonin 3 mg tablet for resident #6 on the medication cart; however, this medication is not indicated on his/her MAR, nor is there an order for the medication.

Plan of Correction

Accept [REDACTED] - 09/15/2025)

Resident #6 had Melatonin tablets on the medication cart without a corresponding order or MAR entry. While inspectors on site, the medication was removed immediately from the home. On 07/29/25 the Director of Wellness contacted the provider to verify there is not existing order for the melatonin. On 07/29/25 following the inspection the Wellness Director re-educated medication associate staff on medication storage and documentation requirements. As of 08/04/25 Weekly audits will be completed for 10 residents' medication records for one month, then monthly audits thereafter. The Wellness Director/administrator will be responsible to conduct these audits

183d - Prescription Current (continued)

and to ensure ongoing compliance. A record of these audits will be kept by the Director of wellness and shared with the administrator monthly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 09/05/2025

Implemented [REDACTED] - 10/30/2025)

185a - Implement Storage Procedures**31. 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 #13 is prescribed Albuterol Sulfate HFA Inhaler, inhale one puff every 4 hours as needed for wheezing. On 7/29/2025 at 2:30 pm, the medication was not available in the home.

Resident #14 is prescribed Tramadol 50 mg tablet, take one-half tablet (25 mg) 3 times a day. According to the resident's July narcotic count sheet, the count for the 2pm dose is 10; however, there were 5 tablets in the card. The count for the 8PM dose is 14; however, there were 7 tablets in the card. The medication has been documented as administered on the residents July MAR.

Repeat Violation: 1/15/25 et al

Plan of Correction

Accept [REDACTED] - 09/15/2025)

Resident #13's albuterol order was an as needed order, and the resident had not had a need for the inhaler in quite some time. Therefore, following the inspection on 07/29/25 the Director of Wellness reviewed the need for the medication with the Provider, and the inhaler was ordered. Resident #4's tramadol counts were not properly documented. On 07/30/25 the Director of Wellness and all Medication Associate Staff were re-educated by the Wellness Director on storage, access, and timely documentation of medications. Additionally, reordering of medications process was reviewed and the proper counting and logging for narcotics was reviewed. As of 08/04/25 Weekly audits of five resident medication records will be conducted for 8 weeks to ensure ongoing compliance. Also, the Director of wellness will check be responsible to check the narcotic book daily to ensure counts are correct. The Wellness Director/administrator are responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: 09/15/2025

Not Implemented [REDACTED] - 10/29/2025)

187d - Follow Prescriber's Orders**32. Requirements**

2600.

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

Description of Violation

Resident #6 is ordered fasting blood glucose monitoring daily, contact PCP if >175. However, the resident did not receive blood glucometer monitoring on July 23, 24, 25, 26 and 28, 2025.

187d - Follow Prescriber's Orders (continued)

Resident #7 is prescribed Tramadol HCL 50 mg, take 1 tablet every 6 hours as needed. However, the medication was administered to the resident in less than a 6-hour interval on 7/15/2025 at 4:31 pm and then again at 7:21 pm.

Resident #12 is prescribed Erythromycin Eye Ointment, apply 1/2 inch ointment to the left eye twice daily for 7 days. The medication was not administered to resident # 12 on 7/29/2025 for the 8A to 11A administration time because it was not available in the home. The medication was only administered for 5 days.

Repeat Violation: 1/15/25 et al

Plan of Correction

Accept [REDACTED] - 09/15/2025)

On 08/04/25 all medication associates were retrained on proper medication administration that includes following the prescribers' orders. Additionally, the Regional Director educated the Director of Wellness on 08/04/25 on the importance of providing daily and routine spontaneous checks as well as structured audits in to verify orders are being followed as per the prescriber. As of 08/04/25 the Director of Wellness will be responsible to audit 5 residents orders weekly for 8 weeks to ensure compliance. While auditing any areas of deficiency will be addressed promptly buy the Director of Wellness and the Director of Wellness will be responsible to notify the Administrator immediately of any areas of deficiency and any corrective action required will be addressed immediately. Documentation of audits will be maintained by the Director of Wellness and Executive Director.

Licensee's Proposed Overall Completion Date: 09/15/2025

Not Implemented [REDACTED] - 10/30/2025)

191 - Resident Right to Refuse

33. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #7, admitted [REDACTED]/2025, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Accept [REDACTED] - 09/15/2025)

Although, resident #7 did not have evidence of being provided the right to refuse, the community has posted the residents rights in a conspicuous area, and this documentation is also supplied in all resident contracts. On 08/01/25 this resident #7 was provided a full list of their rights. By 9/12/25 the Executive Director will review the list of resident's rights at the next resident council meeting. Any residents not in attendance will also have copy issued to them for review. The administrator will request a signed acknowledgement from all the residents that they have received and understand all their rights. This acknowledgment will be kept in the resident's record.

Licensee's Proposed Overall Completion Date: 09/12/2025

Implemented [REDACTED] - 10/30/2025)

225c - Additional Assessment

34. Requirements

2600.

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

- 1. Annually.

Description of Violation

Resident #15 has a diagnosis of mediastinal mass, as indicated on [redacted] medical evaluation dated [redacted]/2025; however, this diagnosis is not included on [redacted] assessment, dated [redacted]/2025.

Plan of Correction

Accept [redacted] - 10/01/2025)

Although, Resident #15's annual assessment was completed dated March 20, 2025, it did not include the diagnosis of mediastinal mass noted in the medical evaluation. On 07/29/25 The Wellness Director had the assessment corrected. On 08/12/25 and 08/13/25 all resident records were audited as part of the communities QA process by a home office QA team member to ensure that all resident records meet regulation 2600.225c. On 08/13/25 the Director of wellness was educated on this regulation by the QA team member.

Audits will be reviewed at the next QA meeting on October 1, 2025 and documentation will be kept in the administrators office.

Wellness Director and Lead Med Tech was educated on this regulation and to ensure that all areas of the form is in compliance. This team will review all current assessments weekly by reviewing 5 residents over the next 8 weeks to ensure all information is correct. Then we will pull 6 residents weekly for 3 months to ensure the audit is completed correctly to meet this regulation.

This regulation will be reviewed on our QA meeting scheduled on October 1, 2025. Audit results will be locked in the administrators office.

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

Not Implemented [redacted] - 10/30/2025)

227g -Support Plan Signatures

35. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #6 did not sign [redacted] support plan dated [redacted]/2025, nor was there an indication that the resident was unable, refused or declined to sign the support plan.

Plan of Correction

Accept [redacted] - 09/15/2025)

On 07/26/25 following the inspection the resident was presented [redacted] care plan to sign and offered a copy. On 08/12/25 and 08/13/25 audits were completed on all resident records by a home office quality team member to ensure ongoing compliance. All areas of deficiency were reported to the Director of Wellness and Administrator and immediate corrections to records were made. On 08/13/25 the Director of Wellness was educated on the 2600.227 and will be responsible to ensure ongoing compliance.

227g -Support Plan Signatures (continued)

Licensee's Proposed Overall Completion Date: 09/05/2025

Not Implemented (█ - 10/30/2025)

252 - Record Content

36. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

- 3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident 7's record does not include a photograph of the resident.

Plan of Correction

Accepted (█ - 09/15/2025)

On 07/25/25 the administrator had resident #7's photo taken and entered into the resident's record. On 07/26/25 the Director of Wellness verified that all other residents' photos were less than two years old and in the residents' records.

On 8/12/25 and 08/13/25 an audit was completed to check all residents' records by the home office QA team member, to ensure that all records were complete to include a current photo of all residents. Additionally, the Director of Wellness was educated on the Tabula Pro system so that he can track when new photos are due that may be approaching the two-year mark or missing upon admission. The Director of Wellness or designee will be responsible to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 09/05/2025

Implemented (█ - 10/28/2025)

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

Facility Information

Name: *ABODE CARE OF MONROEVILLE* License #: *45119* License Expiration: *11/14/2025*
Address: *2560 STROSCHER ROAD, MONROEVILLE, PA 15146*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED]

Legal Entity

Name: *ABODE CARE OF MONROEVILLE LLC*
Address: *2560 STROSCHER ROAD, MONROEVILLE, PA, 15146*
Phone: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *6/4/2012* Issued by: *Municipality of Monroeville*

Staffing Hours

Resident Support Staff: Total Daily Staff: *62* Waking Staff: *47*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *10/27/2025*

Inspection Dates and Department Representative

09/15/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* Residents Served: *36*

Secured Dementia Care Unit

| | | | |
|--------------------|-------|-----------|-------------------|
| In Home: <i>No</i> | Area: | Capacity: | Residents Served: |
|--------------------|-------|-----------|-------------------|

Hospice

Current Residents: *4*

Number of Residents Who:

| | |
|--|--|
| Receive Supplemental Security Income: <i>0</i> | Are 60 Years of Age or Older: <i>36</i> |
| Diagnosed with Mental Illness: <i>0</i> | Diagnosed with Intellectual Disability: <i>0</i> |
| Have Mobility Need: <i>26</i> | Have Physical Disability: <i>1</i> |

Inspections / Reviews

09/15/2025 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/15/2025*

Inspections / Reviews (*continued*)

11/17/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/24/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 11/19/2025

11/20/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/24/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 11/24/2025

12/01/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/24/2025

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

23a - Activities of Daily Living Assistance

1. Requirements

2600.

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

Description of Violation

Resident #1's support plan, dated [REDACTED]/25, indicates the home's plan to meet the service need for transferring in/out of bed/chair is "2 staff members will provide full assistance when transferring" and the mobility assessment indicates the resident is non-weight bearing and requires 2 staff members for all transfers. Also, the resident is ordered a Hoyer lift, which also requires 2 staff persons to transfer the resident. However, staff interviews indicate the resident is transferred with only 1 staff person assisting.

Plan of Correction

Accept [REDACTED] - 11/20/2025)

On 09/15/25 the ED updated residents' assessment and support plan to indicate that the resident does use a Hoyer to transfer and does require a 2 person assist on mobility. Staff was educated to utilize the Hoyer to transfer resident with the assistance of another staff member for safety concerns.

AbodeCare Group will implement enhanced supervision procedures to ensure all staff demonstrate proficiency in safe transfer techniques, including the proper use of Hoyer lifts.

1. Supervision Requirement for All Transfers - A Shift Lead must be physically present to supervise all resident transfers involving a Hoyer lift when the DOW, ED, or ADOW are not on-site. - The Shift Lead will directly observe staff performing the transfer to ensure proper technique, safety, and adherence to established protocols.

2. Competency Verification - Staff must demonstrate proficiency in Hoyer lift operation before performing any mechanical lift independently. - Competency checks will include: • Proper sling application • Safe operation of the lift • Communication with the resident • Use of two-person assistance when required - Any staff member unable to demonstrate proficiency will be retrained before being allowed to participate in transfers.

3. Documentation of Competency - All competency records will be maintained in the Director of Wellness (DOW) office. - Records will include dates of training, competency verification forms, and signatures of both the trainer and the observed staff member.

4. Orientation for New Hires - All new hires will receive training on ADL assistance and Hoyer lift use during their orientation period. - New hires must complete competency verification before providing any Hoyer-lift- related assistance.

5. Ongoing Monitoring - Supervisory staff will conduct routine spot checks to ensure continued adherence to safe transfer procedures. - Annual retraining and competency updates will be required for all direct care staff.

This plan is designed to meet the requirements of PA DHS Regulation 2600.23(a), ensuring that staff are trained, competent, and appropriately supervised when assisting residents with ADLs and mechanical transfers. Documentation will be kept in the administrator's office on site. This regulation will be reviewed at the next scheduled quality meeting which is scheduled for January 16, 2026. Records of the Meeting will be kept in the Administrators office.

Licensee's Proposed Overall Completion Date: 11/19/2025

Not Implemented [REDACTED] - 11/26/2025)

63a - First Aid/CPR Training

2. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 8/5/25 from 12:00 a.m. until 5:00 a.m., there were 36 residents in the personal care home. Direct care staff person A was the only staff person present in the home trained in first aid and certified in obstructed airway techniques and CPR, however, direct care staff person A's certification in obstructed airway techniques and CPR expired in in June 2025.

On 8/10/25 from 11:00 p.m. until 11:59 p.m., there were 36 residents in the personal care home. Direct care staff person A was the only staff person present in the home trained in first aid and certified in obstructed airway techniques and CPR, however, direct care staff person A's certification in obstructed airway techniques and CPR expired in in June 2025.

On 8/11/25 from 12:00 a.m. until 5:00 a.m., there were 36 residents in the personal care home. Direct care staff person A was the only staff person present in the home trained in first aid and certified in obstructed airway techniques and CPR, however, direct care staff person A's certification in obstructed airway techniques and CPR expired in in June 2025.

Plan of Correction

Accept [redacted] - 11/20/2025)

On 09/15/25 following the inspection the Executive Director reviewed the schedules to ensure that adequate CPR coverage going forward. On 10/15/25 a CPR class is scheduled to ensure the community has an adequate coverage to meet the needs of the current census and that is in line with regulation 2600.63a As of September 15, 2025, the Executive Director audited schedules weekly to ensure ongoing compliance for 8 weeks. 11/21/25, the Director of Wellness (DOW) will maintain and post an updated CPR/First Aid expiration tracking sheet in the staff break area, across from the time sheets. This list will clearly show each employee's upcoming expiration date and when they are due for recertification. The DOW will update the list whenever changes occur and will provide the updated version to the Executive Director (ED). After each CPR/First Aid class, the DOW will submit the class sign-in sheet to the ED, who will compare it to the list of employees due for recertification to verify completion. If any Direct Care staff miss their required training, the ED and DOW will develop a corrective plan, which may include rescheduling the staff member or issuing disciplinary action, depending on the circumstances. All Direct Care staff should be scheduled for recertification before their expiration date. Records will be kept in the Executive Director's office. This regulation will be reviewed at the next scheduled quality meeting which is scheduled for January 16, 2026. Records of the Meeting will be kept in the Administrators office.

Licensee's Proposed Overall Completion Date: 11/19/2025

Not Implemented [redacted] - 11/26/2025)

141b1 - Annual Medical Evaluation

3. Requirements

2600.

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

Description of Violation

Resident #1's medical evaluation, dated [redacted]/25, did not include the medical professional's license number. That area of the form was blank..

141b1 - Annual Medical Evaluation (continued)

Plan of Correction

Accept [redacted] - 11/17/2025)

On 09/15/25 resident #1's evaluation was corrected to include the medical professionals license number. 09/30/25 the new DOW audited all the residents' evaluations and made sure that all medical professional license numbers were included on the Medical Evaluation Form. On 09/29/25 the Administrator reviewed and educated the new DOW on regulation 2600.141b and all the documentation requirements in regard to the annual medical evaluation.

Licensee's Proposed Overall Completion Date: 11/14/2025

Not Implemented [redacted] - 11/26/2025)

227d - Support Plan Medical/Dental

4. Requirements

2600.

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

Description of Violation

Resident #1 uses both a trapeze bar and a bedside mobility device that is affixed to the bed for mobility assistance. However, the support plan for the resident, dated [redacted]/25, does not address:

- o The specific need for the bedside mobility device
- o The intended use and any risks associated with the use
- o The resident's ability to use the device safely for the purpose it was intended
- o Identification of the specific device to be used and whether a cover is required to meet FDA guidelines

Plan of Correction

Accept [redacted] - 11/17/2025)

On 09/15/25 the ED amended resident number 1's RASP to address specific need for the bedside mobility device, intended use and any risks associated with the use, residents' ability to safely use the device for the purpose it was intended, identification of the specific devices to be used and whether a cover is required to meet the FDA guidelines. On 09/30/25 the new DOW and Designee audited all residents rasps and profiles to identify any residents that may have a bedside mobility device and to ensure that the applicable RASPS were updated to reflect the specific need for the bedside mobility device, intended use and any risks associated with the use, residents ability to safely use the device for the purpose it was intended, identification of the specific devices to be used and whether a cover is required to meet the FDA guidelines. Any areas of deficiency were corrected. On 11/05/25 the Regional Director had a training with all company Executive Directors and reviewed this regulation on 2600.227d, subsequently all Administrators held trainings with their DOW's. On 11/06/25 the Executive Director reviewed this training with this communities Director of Wellness and Assistant Director of Wellness. This regulation will be discussed at the next scheduled Quality Assurance Meeting which is scheduled for January 16, 2026

Licensee's Proposed Overall Completion Date: 11/14/2025

Not Implemented [redacted] - 11/26/2025)