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

January 30, 2026

[redacted]
PROVIDENCE PLACE OF COLLEGEVILLE ASSOCIATES
[redacted]

RE: PROVIDENCE PLACE AT THE
COLLEGEVILLE INN
4000 RIDGE PIKE
COLLEGEVILLE, PA, 19426
LICENSE/COC#: 14477

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/22/2025, 09/23/2025 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: *PROVIDENCE PLACE AT THE COLLEGEVILLE INN* **License #**: *14477* **License Expiration**: *09/12/2026*

Address: *4000 RIDGE PIKE, COLLEGEVILLE, PA 19426*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *PROVIDENCE PLACE OF COLLEGEVILLE ASSOCIATES*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/02/2020* **Issued By**: *Lower Providence Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *167* **Waking Staff**: *125*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *09/23/2025*

Inspection Dates and Department Representative

09/22/2025 - On-Site: [redacted]

09/23/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *115*

Special Care Unit

In Home: *Yes* **Area**: *Connections* **Capacity**: *47* **Residents Served**: *31*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *115*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *52* **Have Physical Disability**: *0*

Inspections / Reviews

09/22/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/24/2025*

10/29/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/19/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/31/2025*

Inspections / Reviews *(continued)*

11/10/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/19/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/28/2025*

01/30/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/19/2025*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

16c Incident reporting

1. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], at 6:45 pm, resident [redacted] had an unwitnessed fall in their bedroom. Staff noted that the resident was found on the floor on their left side in front of their bed. Staff observed blood on the floor and laceration to the back of the resident head. Resident [redacted] was transported by EMS to Phoenixville Hospital at 6:55 pm. Resident was discharged back to the home on [redacted] with 3 staples to the back of their head. The residence did not report this incident to the Department until [redacted] at 8:30 am.

Repeat Violation: [redacted]

Plan of Correction ***Accept [redacted] - 10/29/2025)***

On 9/23/25, education was provided to the Executive Director by the licensing representative stating that this should have been reported as an initial and then later submit the final information.

On 9/23/25, education was provided to the management team regarding 16c from the Executive Director.

On 9/25/25, Executive Director audited the reportable binder to ensure no other late reporting occurred.

Effective 9/25/25 and moving forward, ongoing monitoring of incidents and incident reporting will be completed by the Executive Director and/or designee to ensure timely completion.

Starting in November, and for three months the clinical audit will be completed to ensure that 16c is being followed and there are no continual concerns. This audit will be completed by the Director of Nursing, Executive Director and/or designee.

This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] - 01/15/2026)

24 Personal hygeine

2. Requirements

2800.
24. Personal Hygiene - A residence shall provide the resident with assistance with personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following:
    1. Bathing.
    2. Oral hygiene.
    3. Hair grooming and shampooing.

24 Personal hygeine *(continued)*

4. Dressing, undressing and care of clothes.
5. Shaving.
6. Nail care.
7. Foot care.
8. Skin care.

Description of Violation

The assessment and support plan, dated [redacted], for resident [redacted] indicates the resident requires assistance with nail care. On [redacted], the resident did not receive this assistance as required.

Plan of Correction ***Accept [redacted] - 10/29/2025)***

On 9/23/25, Our Team Lead in our Connections (secured memory care unit) cut resident [redacted]s nails to appropriate length.

On 9/23/25 the Nursing Coordinator added in our EHR system reminders for weekly nail care for all residents. Nail clippers were purchased & available in Connections and Assisted Living for individual use.

From 9/25/25 10/30/25 the Nursing Coordinator and Connections Director verified that all residents, who need assistance with nail care as provided.

On 10/01/25 10/10/25 education was provided to all direct care staff regarding all expectations of personal hygiene within regulation 2800.24.

This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] - 01/15/2026)

42s Privacy - self/possessions

3. Requirements

2800.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On [redacted] at 9:15 am, the first floor front lounge common area is being recorded.

Plan of Correction ***Accept [redacted] - 10/29/2025)***

• On 9/23/25 the Director of Maintenance reviewed camera locations to assess the most appropriate way to maintain building security and compliance with 42s. [redacted] took the living room camera offline.

42s Privacy self/possessions (continued)

• On 9/30/25 the Director of Maintenance spoke to I.T. about zooming in on specific doors or masking out areas as to not be in violation of 2800.42(s). Technician was able to adjust cameras to resolve privacy issue.

• On 9/23/25 The Director of Maintenance labeled all cameras with "recording in progress" on the camera bodies.

• Moving forward, any additional cameras installed will be labeled by the Maintenance Coordinator and/or designee and positioned/placed in accordance with 2800.42(s). No additional cameras are currently scheduled for install.

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *10/22/2025*

Implemented [redacted] - 01/15/2026)

54a Direct care staff quals

4. Requirements

2800.
54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.
4. Be able to communicate in a mode or manner understood by the resident. Strategies that promote interactive communication on the part of direct care staff and individual residents shall be developed in accordance with the resident's final support plan under § 2800.227(e) (relating to development of the final support plan).

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept [redacted] - 10/29/2025)***

Effective 9/22/25, Staff person A was removed from the schedule until diploma/waiver can be obtained.

On 9/29/25, staff person A was transferred and trained as a Housekeeping Associate which is a non direct care position. A Home Office designee will pursue the waiver process.

From 10/1/25 10/2/25 all direct care employee files were audited for compliance with 54a by the Business Office Manager.

54a Direct care staff quals (continued)

-Beginning 9/22/25 and moving forward, employees will not be permitted to begin on-boarding without valid educational documentation and will use the new hire checklist during hiring process by the Nursing Coordinator, Business Office Manager and/or hiring designee.

-This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *10/22/2025*

Implemented [redacted] 01/15/2026)

62 Contact list

5. Requirements

2800.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person B, the Administrator, does not maintain a list for substitute staff.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

-On 9/24/25 the Nursing Coordinator added the missing information the licensing representatives were looking for, which was the phone number to the contact/training sheet. Moving forward, the form has been updated to reflect all requirements.

-On 9/24/25-10/30/25 the Nursing Coordinator spoke to the LPN/Shift Leads in both Assisted Living and Connections Neighborhood (secured dementia unit) to ensure that all substitute staff must fill out all information required of regulation 62.

-On 9/924/25 Nursing Coordinator or designee will audit the agency binder 3x a week for three weeks to ensure compliance.

-This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *10/22/2025*

Implemented [redacted] - 01/15/2026)

65j Annual training content

6. Requirements

2800.
65.j. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

65j Annual training content *(continued)*

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—10225.708).
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

Staff person C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert and resident rights during training year 2024.

Plan of Correction ***Accept [redacted] - 10/29/2025)***

On 9/24/25 licensing representative indicated that staff person C did not received fire safety or resident rights training during the 2024 year. There is no further action that could be taken since that year has passed.

On 9/24/25 the Business Office Manager audited all ancillary coworker files and identified Resident Rights training was absent from the list. Additionally, all training requirements of 65j were audited for compliance and all other training was in place and/or scheduled for 2025. Business Office Manager coordinated with Home Office, who coordinates training schedule, regarding the missing training and updated the ADP training portal to reflect Resident Rights for the 2026 training year.

From 10/1/25 10/8/25 all ancillary staff will receive training on resident rights (regulation 42a z) from the Business Office Manager and/or designee to fulfill the 2025 training requirement.

10/15/25 10/16/25 our fire safety expert completed training for the ancillary employees that had missed their annual fire training.

Starting 10/30/25 and moving forward, Executive Director and/or designee will monthly review all new hires information to ensure compliance with 65j.

This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented ([redacted] - 01/15/2026)

82c Locked poisons

7. Requirements

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

82c Locked poisons *(continued)*

Description of Violation

Hand sanitizer, with a manufacturer's label indicating "Do not swallow, keep out of reach of children", was unlocked, unattended, and accessible to resident [redacted] Not all the residents of the residence, including resident [redacted] have been assessed capable of recognizing and using poisons safely.

Efferdent tablets, with a manufacturer's label indicating "this product contains persulfates, which may cause allergic reactions. In case of accidental ingestion, contact a poison control center immediately", was unlocked, unattended, and accessible in resident [redacted] bathroom drawer. Not all the residents of the residence, including resident [redacted] have been assessed capable of recognizing and using poisons safely.

Repeat Violation: [redacted] *et al.*

Plan of Correction ***Accept*** [redacted] ***- 10/29/2025)***

-On 9/22/25 The Connection Director immediately locked up the chemicals for residents [redacted] *and* [redacted]

-On 11/1/25 and moving forward for three months, Direct care and/or designee will complete daily room audits of all connections room to ensure each room is audited on a monthly rotation for three months. Additionally, Connection Director and/or designee will spot check rooms for compliance.

-Starting in November and for the next three months, the Director of Nursing, Executive Director, home office coworker and/or designee will complete a clinical QA to ensure practices are being followed.

-This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] ***- 01/15/2026)***

85a Sanitary conditions

8. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted]*, at 9:30 am, there were brown stains, and a red substance in the freezer. There were spilled coffee grounds and creamers in the cabinet drawers and 4 leaking juice cartridges underneath the cabinet in the 2nd floor kitchen pantry. At 9:39 am, there was a brown substance on the wall in memory care activities area. At 9:52 am, the floor in front of the dining area was sticky and there was pink juice leaking from the juice machine. At 10:00 am, there was a strong odor of* [redacted] *and soiled briefs in the common bathroom in memory care. At 10:16 am, there was* [redacted] *in the back of the toilet riser in room 105. At 10:30 am, there was a jug of vanilla extract covered in grim and a sticky substance dripping on other bottles on the rolling rack in the kitchen. There was also white powder spilled all over everything on the rolling rack in the kitchen.*

85a Sanitary conditions (continued)

Plan of Correction ***Accept [redacted] - 10/29/2025)***

On 9/22/25 when the DHS licensing representative stated there were sanitation issues throughout the community, the housekeeping team reported to the pantry and deep cleaned the pantry, the Connections (memory care) activities area and the toilet rise in room 105, the common area bathroom in memory care and the dining area. The Dining team cleaned the rolling racks in the main kitchen.

On 9/22/25 10/30/25 the Housekeeping Manager educated the Shift Leads and Med techs (the shift supervisors), dining staff and housekeeping staff regarding the expectations of 85a.

Beginning the week of 9/23/25 weekly audits will be completed for sanitation of the pantry. Audits will be completed 3x a week by Housekeeping Manager, Dining Director and/or designee for a total of 4 weeks. As of 10/15/25 and moving forward, Housekeeping will continue to oversee daily housekeeping needs in the memory care's common area bathrooms and common areas for sanitation concerns for three months. Housekeeping Manager and/or designee will complete routine spot checks of housekeepers completed work. As of 10/25/25 Dining team has implemented a new cleaning schedule to ensure that all areas of the kitchen are being addressed. Dining Director and/or designee will complete routine spot checks of dining's completed work.

This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] - 01/15/2026)

85b Infestation

9. Requirements

2800.
85.b. There may be no evidence of infestation of insects or rodents in the residence.

Description of Violation

On [redacted] at 9:52 am, there were flies on a partially opened container of apple cider vinegar and more flies hovering around makeshift fly traps on the counter.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

On 9.22.25, Dining Director spent time cleaning and organizing this area. The Dining Director identified that some of the concerns were due to a housekeeping closet in the kitchen area. This closet was deep cleaned and reorganized, unnecessary items removed, and proper supplies were in place.

85b Infestation (continued)

- On 9.30.25, Dining & Connections Director discussed a plan for improving and monitoring sanitation in connections kitchen. This will include a Housekeeping team member, or designee, specifically tasked with some roles of overseeing the Connections kitchen. The Dining director, or designee, will hold an education from 9/30/25-10/26/25 with the housekeeping member & shift/team leads in connections on (Reg 85b).

-Starting the week of 10/5/25 for three months, Connections kitchen will be spot checked for overall sanitation and needed cleaning, at minimum 3 times a week by Dining Director and or designee.

-This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented [redacted] - 01/15/2026)

85d Trash cans – kitchen/bath

10. Requirements

2800.
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 [redacted], at 9:29 am, there was an uncovered trash can ¼ full with gloves and food wrappers in the second-floor dining area.

On [redacted] at 9:55 am, there was unattended and uncovered trash can on the kitchen cart filled with food.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

-On 9.22.25 the Dining Director went to the second floor dining area and main kitchen to ensure lids were on the trash cans.

-Between 9.24.25 – 10.26.25 – The Dining Director, or designee, provided education to all Dining, Housekeeping & Connections staff to discuss all violations, including trash can lids requirement (Reg. 85d)

- On 10.2.25 – Dining Director created & posted (Reg 85d) reminders on all trash cans in our Main Kitchen, Connections Kitchen & Pantry area.

-Starting the week of 10.5.25 for one month, all common area bathrooms and kitchen trash cans will be spot checked three times per week for compliance by the Dining Director and/or designee.

-This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

85d Trash cans – kitchen/bath (continued)

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented (- 01/15/2026)

85e Trash outside

11. Requirements

2800.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On at 10:21 am, the following were observed: gloves and a piece of cloth outside stairwell C underneath the loading dock; pallets and a television behind the dumpster located outside; cardboard refrigerator box and dog cage next to the dumpster located outside; gloves and food wrappers around AC units outside.

Plan of Correction ***Accept (- 10/29/2025)***

On 9/22/25 when the licensing representative stated that there was trash not in covered receptacles near the dumpsters/loading dock area. Noted by the representative were gloves and cloth outside of stairwell "C" and under the loading dock, pallets and a television behind the dumpsters, a refrigerator box and a dog cage adjacent to dumpsters. As well gloves and food wrappers around the outside A/C condensers. The Housekeeping Manager/Maintenance Director immediately reported to the area and addressed the issues and cleaned the area.

On 9/22/25 the Housekeeping Manager educated the coworkers on Dining and Housekeeping staff regarding the cleanliness/sanitation of the loading dock and dumpster area.

On 10/1/2025 reminder signs were posted on the dock to ensure proper sanitation. Tools were placed by dumpsters/loading dock to assist in these efforts.

Beginning the week of 9/29/25 weekly audits will be completed 3x a week for four weeks focusing on the sanitation of the dumpster's and loading dock area by Housekeeping, Dining, Maintenance and/or designee

This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *10/24/2025*

Implemented (- 01/15/2026)

95 Furniture & Equipment

12. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

95 Furniture & Equipment *(continued)*

Description of Violation

Resident [redacted]s bedside table is broken the front of the cabinet fell off when touched.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

• On 9/22/25 when the DHS licensing representative cited broken hinge on bedside table in violation of RCG 2800.95, the Maintenance Director remedied immediately by reattaching hinge on 9/22/25.

• On 10/1/25 the Maintenance team was educated and trained by the Director of Maintenance to maintain compliance by reviewing RCG 2800.95.

• Starting on the week of 9/29/25 for (4) weeks, bedside tables will be checked (1x) weekly at no less than (6) locations throughout the building by Director of Maintenance or designee.

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *10/24/2025*

Implemented ([redacted] - 01/15/2026)

101j5 Bedside table/shelf

13. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident [redacted]s bed in living unit [redacted]

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

• On 9/22/25 while doing room audits, the licensing representative found room 146 was missing a bedside table. The Maintenance Director immediately corrected the issue by putting a bedside in the resident [redacted]s room.

• On 9/24/25 Sales Director was educated on regulation 101j and to help educate families upon move in of this requirement.

• On 10/21/25 the Sales Director audited all the rooms for the move ins over the past three months to determine that a bedside table was in place.

• On 10/30/25 and moving forward for the next three months, direct care and/or designee will complete daily room audits of all Connection rooms to ensure each room is audited on a monthly rotation. Additionally, Connection Director and/or designee will spot check rooms for compliance.

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

101j5 Bedside table/shelf (continued)

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented ([redacted] - 01/15/2026)

103e Leftovers

14. Requirements

2800.
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

There were 3 unlabeled, undated black to go food containers in the refrigerator in memory care activities room.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

-On 9.22.25, Dining Director deep cleaned the refrigerator, removed, and discarded all undated or unlabeled products. The Dining Director also checked all other common area refrigerators to ensure there was no unlabeled and undated food.

- On 9.30.25, Dining & Connections Director discussed a plan for improving and monitoring sanitation in connections kitchen. This will include a Housekeeping team member, or designee, specifically tasked with some roles of overseeing the Connections kitchen and memory care activities refrigerator. From 9/25/25-10/25/25, The Dining director, or designee, will hold an education with the housekeeping member & shift/team leads in connections on Reg 103e.

-Starting the week of 10.5.25 for one month, Connections refrigerators will be checked at minimum 3 times per week by Connections Director/Dining Director, or designee, to ensure compliance with standard.

-This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/03/2025*

Implemented ([redacted] - 01/15/2026)

103f Fridge/Freezer Temps

15. Requirements

2800.
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 [redacted] at 9:30 am, the temperature in the 2nd floor pantry refrigerator measured 44 degrees Fahrenheit.

103f Fridge/Freezer Temps (continued)

On [redacted] at 10:27 am, the temperature in the prep refrigerator measured 42 degrees Fahrenheit.

On [redacted], at 10:28 am, the temperature in the main freezer measured 4 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

On 9.22.25 the licensing representative reported the main freezer was showing 4, prep fridge at 42*, pantry at 44*. When Dining Director arrived, they went to these units to inspect. Main freezer was currently reading 1* and the Director lowered internal thermostat controls to 6* for better leeway in temperature fluctuations. Prep fridge was noted at 38* and set temp lowered to 34.6. The other prep fridge thermometer had some damage and was replaced as readout was hard to determine accurately. Pantry refrigerator had no thermometer present to gauge actual air temperature, only a digital control to set desired temperature. Thermometers were added to both the refrigerator and freezer in the pantry and monitored to watch temps. These fell to 36/37* and 6* respectively.*

On 9.24.25 The Dining Director held an education for the Dining Staff to discuss all violations, including temperatures for cold storage (Reg 103f).

Starting the week of 10.5.25 for one month, all dining area refrigeration temperatures will be spot checked three times per week for compliance by the Dining Director and/or designee.

This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented ([redacted] - 01/15/2026)

103g Storing food

16. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

The 4 containers of ice cream in the ice cream freezer were opened and unsealed.

Repeat Violation: [redacted] et al

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

On 9.22.25 lids were placed on the ice cream containers and Dining director purchased more plastic ice cream covers to have extras.

Between 9.24.25 to 10.15.25, The Dining Director held an education with Dining Staff to discuss all violations, including the need to properly cover all food items Reg 103g.

Starting the week of 10/5/25 for one month, the Main kitchen and all its storage areas will be spot checked 3 per week to assure all items are properly covered/sealed.

103g Storing food (continued)

Starting in November the Providence Place Dining Quality Audit will be completed monthly for three months by the Dining Director, Executive Director, Home Office worker and/or designee.

This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/03/2025*

Implemented ([redacted] - 01/15/2026)

103i Outdated food

17. Requirements

2800.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On [redacted], at 9:30 am the following were observed:

- *Unlabeled, undated bag of sugar or salt that was sticky to the touch in the 2nd floor food pantry*
- *One dented can of artichoke hearts*
- *Unlabeled, undated bag of berries in the 2nd floor kitchen refrigerator*
- *Unlabeled, undated frozen shrimp and french fries in the freezer*

Repeat Violation: [redacted] et al

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

On 9.22.25 when the licensing representative stated there was a dented can and unlabeled in food in the refrigerator and freezer the Dining Director reported to those areas. The can in question was marked and removed from pantry for proper return/disposal. Can was placed outside the Dining Directors office. The unlabeled food items were removed.

On 9.24.25, The Dining Director held a meeting with Dining Staff to discuss all violations, including the need to remove any and all dented cans to outside of directors office for proper disposal or return and ensure all food items are labelled.

On 10.1.25 Signage was created and placed around dry storage with reminders to check for and remove dented cans upon arrival. A sign was also placed on the second floor pantry reminding the requirement of ensuring all food must be labeled.

Starting the week of 10.5.25 for one month, dry storage will be spot checked 3 times weekly by Dining Director or Designee, to assure we are removing all dented cans and no unlabeled food in the refrigerators/freezers.

103i Outdated food (continued)

-For the next three months, starting in November, the Providence Place Dining Quality Audit will be completed monthly by Dining Director, Executive Director, Home Office worker and/or designee.

-This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/03/2025*

Implemented ([redacted] - 01/15/2026)

125a Combustible storage

18. Requirements

2800.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

The home is storing multiple papers and plans on top of the elevator motors system that was hot to the touch.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

• On 9/22/25 when the DHS licensing representative cited papers being stored on mechanical equipment in violation of RCG 2800.125(a), the Maintenance Director remedied immediately, in front of inspector by removing the papers/drawings from the mechanical room. These paper were left temporarily and are not a permanent location.

• On 10/1/25, Maintenance was educated and trained by the Director of Maintenance to maintain compliance by reviewing RCG 2800.125(a).

• Starting on the week of 9/29/25 for (4) weeks, elevator mechanical room shall be monitored (3) times weekly by the Director of Maintenance or designee to ensure compliance. A sign was placed on the door to the room to remind anyone that no additional items should be kept in the room.

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *10/24/2025*

Implemented ([redacted] - 01/15/2026)

141a Medical evaluation

19. Requirements

2800.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.

141a Medical evaluation *(continued)*

2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.
12. Information about a resident's day-to-day assisted living service needs.

Description of Violation

The medical evaluation for resident [redacted] dated [redacted], does not include the resident's ability to self-administer medications. This area of the form is blank.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

On 9/25/25 PCP reviewed DME for resident [redacted] and updated the DME accordingly.

From 9/22/25-10/15/25, Executive Director reviewed all of the DMEs in Assisted Living to ensure that the DME's were accurately completed and found no additional errors.

From 9/23/25-10/3/25 education was provided to the LPNs and Sales team on the requirements of 141a.

Effective 9/23/25 and moving forward, all residents' medical evaluations will be reviewed for accuracy by the Director of Nursing and/or Designee.

This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented ([redacted] - 01/15/2026)

20. Requirements

2800.

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

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.

141a Medical evaluation *(continued)*

7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.
12. Information about a resident's day-to-day assisted living service needs.

Description of Violation

The medical evaluation for resident [redacted] dated [redacted], does not indicate the tuberculin skin test has been administered.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

-On 9/22/25 Resident [redacted] was administered [redacted] TB by the LPN Shift Lead and results on 9/24/25 indicated [redacted] was negative for TB.

-From 9/23/25-10/3/25 education was provided to the LPNs and Sales team on the requirements of 141a.

-Effective 9/23/25 and moving forward, all residents will receive a TB test annually or within 15 days of move in by the LPN. On 10/3/25 TB tracker and audit was created by Executive Director and/or designee to reference and ensure timely tests are completed and a move in checklist was created to remind Shift Leads/LPNs to administer TB when/if needed at move in.

This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented ([redacted] - 01/15/2026)

162c Menus - posted

21. Requirements

2800.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The residence's menu for the week of [redacted] was posted. However, the week of [redacted] was not posted in personal care or memory care.

Repeat Violation: [redacted]

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

-On 9.22.25 Dining Director posted all menus in three required dining areas, as per 162c regulation requirement.

162c Menus - posted (continued)

-Between 9.24.25 & 10.15.25 the Dining Director, or designee, held an education with Dining Staff & Reception team to discuss this violation, and the need to be sure we are changing these menus weekly. Beginning 10/11/25 and moving forward, the reception team will be responsible for updating the menus in these locations.

-Starting the week of 9/28/25 for one month, all dining room menus will be checked by the Dining director or designee, three times a week.

-Starting in November for three months the Providence Place Dining Quality Audit will be completed monthly by the Dining Director, Executive Director, Home Office worker and/or designee.

-This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *10/24/2025*

Implemented ([redacted] - 01/15/2026)

162e Menu changes

22. Requirements

2800.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On [redacted] at 11:56 am, red pepper soup with toasted croutons, ham salad sandwich, parmesan tots, and fruit salad were listed on the menu for lunch in Connections. Tomato soup was served instead. No notice was provided to the residents in advance of the meal.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

~~*-On 9.22.25 The cook who prepared the soup was questioned regarding what soup was made, and confirmed [redacted] prepared the soup that was posted on all menus in the community. Cook prepared a written statement. Daily and current menus were posted in Connections area reflecting the correct soup without changes needed. [redacted] 10/29/25*~~

- On 9.23.25 The cook who had prepared the soup was interviewed by the licensing representatives.

-On 9.24.25 Dining Director held an education with Dining Staff to discuss all violations, including discussing this violation, and educating staff on the need for posted signage and notification as soon as any menu change is made.

- Between 9.24.25-10.15.25 an education was held with Connections staff on reviewing the daily menus prior to every service to ensure they are informed on what they are serving to residents.

- On 10.1.25 A menu change notification form was created should this be needed in the future, additionally an additional copy of the daily menu is now being placed with the hot box for quicker review for the connections team.

162e Menu changes (continued)

-This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Proposed Overall Completion Date: 10/24/2025

Licensee's Proposed Overall Completion Date: *10/24/2025*

Implemented ([redacted] - 01/15/2026)

181c Self-Administer Assessment

23. Requirements

2800.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident [redacted] self-administers medications to include [redacted] and [redacted]; however, resident [redacted] has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

-On 9/24/25 the resident assessment for Resident [redacted] was reviewed with the PCP and it was updated to reflect a proper assessment regarding medication administration.

-From 9/23/25-10/3/25 education was provided to the LPNs and Sales team on the requirements of 181c.

-From 9/22/25-10/15/25, Executive Director reviewed all of the DMEs in Assisted Living to ensure that the residents assessment's were accurately completed and found no additional errors. Starting in November and moving forward monthly, Executive Director and/or designee will audit all new resident charts for resident's assessment regarding medication administration.

-This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *10/24/2025*

Implemented ([redacted] - 01/15/2026)

183b Medications and syringes locked

24. Requirements

2800.

183b Medications and syringes locked *(continued)*

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

Description of Violation

On [redacted] at 10:16 am, resident [redacted] is prescribed [redacted], and the medication was unlocked, unattended, and accessible in resident [redacted] s bathroom.

On [redacted], at 9:50 am, resident [redacted] is prescribed [redacted] and [redacted] and the medication was unlocked, unattended, and accessible in the resident's bedroom.

Repeat Violation [redacted] et al.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

-On 9/22/25 The Executive Director immediately removed the medication and gave it to the LPN/Shift Lead to review w/MAR and PCP and educated to coworkers on that shift in both Assisted Living and Connections Neighborhood (secured dementia unit) to ensure that all medication (in Assisted Living) must have a physician order to be kept at bedside and must be secured in a locked area in resident's apartment.

-On 9/25/25 Nursing Coordinator and/or designee reviewed all Assisted Living resident DME's to determine their ability to self-administer medication. From 10/02/25-10/18/25 all residents had room checks to confirm if medication was present and/or secured aligning with their DME.

-From 10/10/25 and 10/27/25 Executive Director discussed the requirements of medication during [redacted] weekly letter to residents, families and all coworkers. Executive Director also discussed this at the monthly resident meeting held on 10/15/25.

-Beginning 11/1/25 and moving forward for three months, direct care staff and/or designee will complete daily room audits to ensure compliance with 183b.

-Starting on 10/1/25 and moving forward, residents will be assessed quarterly, by the Director of Nursing and/or designee, to determine their ability to self-administer any medication. For the next three months starting in November, the Providence Place Clinical Audit will be completed monthly by the Director of Nursing, Executive Director, Home Office worker and or designee.

-This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

183b Medications and syringes locked (continued)

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented (- 01/15/2026)

183e Storing Medications

25. Requirements

2800.
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

Resident is prescribed take 2 every 8 hours. On the blister pack had a tear on number 55, and the pill was still in the package.

Resident is prescribed take every 4 hours as needed. On the blister pack had a tear on number 18 and number 25, and the pills were still in the package.

Resident is prescribed tab take twice daily. On the blister pack had a tear on pill number 18 and the pill was still in the package.

Repeat Violation: et al.

Plan of Correction ***Accept (- 10/29/2025)***

• On 9/23/25 Med Tech removed resident blister packs from the cart and sent back to pharmacy for repackaging.

• From 9/23/25-10/30/25 all Med Techs and LPNs received education on 183e and to ensure when cart audits are done and during medication passes that review of blister packs and expired medications are a focus.

• On 9/23/25 and moving forward, Med Tech or designee will implement a weekly audit of residents' medication to ensure each blister pack is free from tears and non expired medication; therefore, in compliance with 183e.

• Monthly and for the next three months the Director of nursing, Executive Director, Home office coworkers and/or designee will complete a clinical QA to ensure practices are being followed.

183e Storing Medications (continued)

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented (- 01/15/2026)

26. Requirements

2800.
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

Resident is prescribed . On , the medication was available on the medication cart however the medication expired on .

Plan of Correction ***Accept (- 10/29/2025)***

• On 9/23/25 MedTech removed resident s medication that was expired and ordered new.

• From 9/23/25-10/30/25 all Med Techs and LPNs received education from the Connections Director and/or designee on 183e and to ensure when cart audits are done that there is a focus on expired medications.

• On 9/23/25 and moving forward, Med Tech or designee will implement a weekly audit of residents' medication to ensure the cart is free from non expired medication; therefore, in compliance with 183e.

• Monthly and for the next three months the Director of nursing, Executive Director, Home office coworkers and/or designee will complete a clinical QA to ensure practices are being followed.

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented (- 01/15/2026)

185a Storage procedures

27. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

185a Storage procedures *(continued)*

Description of Violation

On [redacted], at 9:43 am, the glucometer for resident [redacted] was not calibrated to the correct time the time display read 9:53 am.

On [redacted] at 9:47 am, the glucometer for resident [redacted] was not calibrated to the correct the time display read 9:04 am.

On [redacted] at 10:26 am, the glucometer for resident [redacted] was not calibrated to the correct time the time display read 10:44 am.

Repeat Violation: 11/18/2024 et al

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

• On 9/25/25 Med Tech audited all glucometers in the community to determine that they were corrected to the appropriate time.

• On 9/25/25-10/30/25 Med Techs and LPNs were educated by the Executive Director and/or designee on the expectation of 185a.

• Starting on 9/25/25, the Med Tech and/or LPN will audit three residents glucometers for correct time and date, weekly for three times then twice for two weeks then for once per week for one week. This audit will end 10/12/2025.

• Monthl

• This violation and plan of correction will be reviewed monthly in our quality ay and for the next three months the Director of nursing, Executive Director, Home office coworkers and or designee will complete a clinical QA to ensure practices are being followed.ssurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented ([redacted] - 01/15/2026)

187b Date/time of med admin

28. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident [redacted] is prescribed [redacted] sliding scale with meals three times a day blood sugar [redacted] On [redacted], and [redacted] the glucometer readings were not record on the medication administration record.

187b Date/time of med admin *(continued)*

Plan of Correction ***Accept (- 10/29/2025)***

• On 9/25/25 LPN audited all glucometers to ensure there is one glucometer assigned per person.

• On 9/25/25-10/30/25 All Med Techs and LPNs were educated by the Executive Director and/or designee on the expectation of 187b.

• Starting on 9/29/25 the Executive Director will audit three resident's glucometer readings verse their medication administration record for three weeks. This audit will end 10/17/2025.

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *10/24/2025*

Implemented (- 01/15/2026)

187d Follow prescriber's orders

29. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident has a physician order for blood glucose checks daily at 8:00 am. The medication administration record for September 2025 for resident has a blood glucose reading of on . However, the resident's glucometer does not have a reading of recorded for .

Repeat Violation: et al,

Plan of Correction ***Accept (- 11/10/2025)***

• On 9/25/25 LPN audited all glucometers to ensure there is one glucometer assigned per person.

• On 9/25/25-10/30/25 All Med Techs and LPNs were educated by the Executive Director and/or designee on the expectation of 187d.

• Starting on 9/25/25, the Med Tech and/or LPN will audit three residents glucometers for correct time and date, weekly for three times then twice for two weeks then for once per week for one week. This audit will end 10/12/2025. Starting 10/31/25 The Director of Nursing and/or designee will audit the glucometers three times a week for two weeks to ensure they match the MAR.

• Monthly and for the next three months the Director of nursing, Executive Director, Home office coworkers and or designee will complete a clinical QA to ensure practices are being followed.

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This

187d Follow prescriber's orders (continued)

will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented (- 01/15/2026)

225a1 Assessment – annually

30. Requirements

2800.
225.a.1. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: Annually.

Description of Violation

Resident s most recent assessment was completed on . The resident's annual assessment was not completed for 2025.

Plan of Correction ***Accept (- 10/29/2025)***

• On 9/24/25 Executive Director audited Resident s chart for annual assessment for 2025. The Executive Director was able to locate the annual assessment in the thinned charts filed in the Director of Nursing files, in error.

• On 9/23/25 Executive Director implemented a new system to identify if a chart has been thinned through stickers placed on the chart. The Executive Director also reorganized all the thin charts in the Director of Nursing office to ensure it is easy to identify a resident's chart/paperwork.

• Effective 9/23/25 and moving forward, the Executive Director and/or designee created a tracker to determine who is due for an annual evaluation.

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *10/22/2025*

Implemented (- 01/15/2026)

227d Support plan – med/dental

31. Requirements

2800.

227d Support plan – med/dental *(continued)*

227.d. Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

On [redacted], resident [redacted]s support plan determined that the resident needs assistances with toileting. The resident's support plan, dated [redacted] does not address how this need will be met.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

• On 9/22/25 the licensing representative found that resident [redacted]s support plan needs assistance with toileting, and it did not address the need. The Connection Director immediately updated the support plan to match resident care needs.

• On 9/23/25 the licensing representatives educated the Executive Director and [redacted] the Connections Director on the expectations of the 227d.

• On 10/15/25 and moving forward the Connection Director or designee did an immediate review of all support plans to ensure their needs were addressed.

• Starting in November and moving forward monthly, the Executive Director and/or designee with audit all new resident charts and annual support plans to ensure care plans match the needs of our residents.

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented ([redacted] - 01/15/2026)

251b Record entries - legible

32. Requirements

2800.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident [redacted]s RASP dated [redacted] was wrote over the original date of [redacted] on the signature page.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

• On 9/22/25 the licensing representative found that the date on the RASP of Resident [redacted] was not legible. The Connections Director made note of this by the licensing representative but could not change the date.

• On 9/23/25-10/15/25 the Connection Director and/or designee completed a chart audit to ensure that all RASP dates are legible.

251b Record entries - legible (continued)

• Starting in November and moving forward monthly for three months, the Executive Director and/or designee will review all dates on RASP's of new move ins and annual RASPs.

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented ([redacted] - 01/15/2026)

252 Records – content

33. Requirements

2800.

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

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. A language, speech, hearing or vision need which requires accommodation or awareness of during oral or written communication.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the residence, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the residence, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2800.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

252 Records – content *(continued)*

27. A record relating to any exception request under § 2800.229 (relating to excludable conditions; exceptions).
28. Ongoing resident progress notes.

Description of Violation

Resident [redacted]s individual record does not include a photograph that is no more than 2 years old.

Plan of Correction ***Accept ([redacted] - 10/29/2025)***

• On 9/25/25 Connections Director went to take a new photo of Resident [redacted] and realized that the photo was updated in the appropriate timeline, so no immediate action was required.

• By 11/30/25 Connections Director and/or designee will take all updated photos of residents and update their face sheets accordingly. Moving forward, all new photos will be taken on the same day as their TB test so that it is one due date for both items.

• This violation and plan of correction will be reviewed monthly in our quality assurance meetings, by our management team for the months of October, November and December 2025 and then yearly or as needed. This will prevent any repeat violations.

Licensee's Proposed Overall Completion Date: *11/28/2025*

Implemented ([redacted] - 01/15/2026)