pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **KAYMARIE BRIDDELL**
LEGAL ENTITY

To operate **VINE STREET MANOR**
NAME OF FACILITY OR AGENCY

Located at **230 NORTH 65TH STREET, PHILADELPHIA, PA 19139**
(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 **84**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

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 **January 14, 2026** until **July 14, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **142341**

ISSUING OFFICER

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.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 14, 2026

[redacted]
KayMarie Briddell
[redacted]

RE: Vine Street Manor
230 North 65th Street
Philadelphia, Pennsylvania 19139
License #: 142341

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection July 22 and 23, 2025 and September 25, 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 REVOKES your certificate of compliance 142340 dated April 18, 2025 to April 18, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST 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) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from JANUARY 14, 2026 to JULY 14, 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.

[redacted]

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 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
20.b.1	III	62	$3	$186	15 calendar days from mailing date of this letter
42b	II	62	$5	$310	5 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 FIRST 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 FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
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

[redacted]

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

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *VINE STREET MANOR* **License #:** *14234* **License Expiration:** *04/18/2026*

Address: *230 NORTH 65TH STREET, PHILADELPHIA, PA 19139*

County: *PHILADELPHIA* **Region:** *SOUTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *KAYMARIE BRIDDELL*

Address: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date:** *09/07/2018* **Issued By:** *Phila L&I*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date:** *07/23/2025*

Inspection Dates and Department Representative

07/22/2025 - On-Site: [redacted]

07/23/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served:** *61*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *48* **Are 60 Years of Age or Older:** *48*

Diagnosed with Mental Illness: *32* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *3* **Have Physical Disability:** *0*

Inspections / Reviews

07/22/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/22/2025*

08/26/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/20/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/31/2025*

09/04/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/20/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/01/2025*

10/30/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/20/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

[redacted]

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 7/22/2025, at 10:35 am, an agent of the Department, requested access to records. Staff person A did not provide the access to the necessary records to include office of emergency management letter, fire department notification letter, fire safety inspection letter, boiler certificates, resident financial records, resident 1's refund information, reportables for the past year, resident council meetings, quality management meetings. These records were not provided until the following day of the inspection.

Plan of Correction ***Accept [redacted] - 08/26/2025)***

This regulation is important because immediate access to facility records ensures that the Department can verify compliance, protect resident rights, and act swiftly to address safety concerns.
Immediate action taken: The Administrator ensured all requested documentation was transmitted to inspectors once staff accessed the system. Staff were unfamiliar with how to properly access the online drive during inspection, which delayed access. Facility administrators and on-site staff will receive training in technology use and file access, including the proper retrieval of compliance documents from shared drives. Training will take place on August 27th, 2025.
The Administrator will conduct a monthly review of staff competency in accessing records, ensuring that documents can be retrieved promptly upon request. Monthly reviews will last for 3 months unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *08/22/2025*

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

[redacted]

[redacted]

20b1 - Financial Records

3. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

The home manages the finances for resident 2. However, The home does not maintain a record of financial transactions.

The home manages the finances for resident 3. However, The home does not maintain a record of financial transactions.

The home manages the finances for resident 4. However, The home does not maintain a record of financial transactions.

The home manages the finances for resident 5. However, The home does not maintain a record of financial transactions.

Repeat violation 8/7/2024 et al.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Immediate action was taken by the administrator reviewing financial records correctly on 7/23/25. The Administrator scheduled a full in-service technology training day on August 27th for administrative staff, with special emphasis on locating and presenting financial folders. Records were available but not accessed correctly while inspectors were in the facility.
A weekly financial log review will be implemented to confirm proper access and reconciliation with the official records starting September 5th.
Monitoring: Starting September 5th, Administrators will review financial access weekly and confirm alignment with consultant-maintained records. This will continue for one month, unless an extension is necessary.

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

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

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.

25a - Written Contract and Review *(continued)*

Description of Violation

Resident 6, admitted [redacted]/2021, did not have a resident-home contract completed until 5/27/2021.

Plan of Correction ***Accept ([redacted] - 09/04/2025)***

A notation will be added to the resident's file explaining The Administrator will continue monitoring all contract start dates, as this system has been effective since 2021. Notation will be added on or before September 5th.
Monitoring: The Administrator will review contracts for new admissions monthly, starting September 5th. This will last for 3 months, unless an extension is found to be necessary.

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

Implemented [redacted] - 10/30/2025)

28e - Death of a Resident

5. Requirements

2600.
28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident 1 passed away on [redacted]/2025. Resident 1's personal belongings were removed from [redacted] room on [redacted]28/2025; however, the resident's designated person was not made aware of a refund for the remainder of previously paid charges. The family did not receive an itemized written account statement.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Immediate action was taken on 7/23/25 by the administrator informing the designated person that a refund will be given to them.
A written refund will be prepared and mailed to the designated person before August 30th, 2025.
Starting September 5th, the Administrator will implement a refund checklist for all resident deaths, including documentation of refund, notification to family, and itemized statement.
Monitoring: Starting September 5th, refund processing will be reviewed in monthly compliance meetings by the administrator to ensure adherence. This will last for 3 months, unless an extension is found to be necessary.

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

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

63a - First Aid/CPR Training

6. 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 7/13/2025 thru 7/19/2025, from 11:00 pm until 7:00 am, 61 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid, obstructed airway techniques and CPR.

63a - First Aid/CPR Training *(continued)*

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Immediate action was taken by the administrator requesting that all certificates be directly to them on 7/23/2025. Staff had received updated certifications, but they were not filed. Staff members received CPR training on August 18th, 2025.

On or before August 27th, HR will implement a compliance checklist to ensure all certifications are logged immediately upon completion.

Starting September 5th, the Administrator will audit staff files quarterly to confirm presence of updated certifications. This will continue for one year unless an extension is found to be necessary.

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

Implemented [redacted] - 10/30/2025)

65a - FS Orientation 1st Day

7. Requirements

2600.

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

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

Description of Violation

Staff person B, whose first day of work was [redacted]/2025, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Immediate action was taken August 1st by assigning a designated trainer [redacted] to provide fire safety and emergency preparedness training to new hires. However, staff person B resigned from employment at Vine Street Manor before training was completed.

Starting September 5th, an orientation checklist will be implemented by the administrator to ensure all staff members complete training their first day. Monitoring: Starting September 5th, HR will conduct semi-annual audits of orientation logs to confirm compliance. This process will last one year unless an extension is found to be necessary.

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

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

65b - Rights/Abuse 40 Hours

8. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B completed his/her 40th scheduled work hour on 1/29/2025. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Immediate action was taken August 1st by assigning a designated trainer [redacted] to provide training on resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions to all new hires. However, staff person B resigned from employment at Vine Street Manor before training was completed.
Starting September 5th, an orientation checklist will be implemented by the administrator to ensure all staff members complete training their first day. Monitoring: Starting September 5th, HR will conduct semi-annual audits of orientation logs to confirm compliance. This process will last one year unless an extension is found to be necessary.
Starting September 5th, all new staff will be placed on a 40-hour compliance checklist to ensure completion within required timeframe. The checklist and all staff training records will be audited every 6 months by HR starting September 5th. Audits will last one year unless an extension is found to be necessary.

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

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

85a - Sanitary Conditions

10. Requirements

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

Description of Violation

On 7/22/2025 at 2:39 pm, There was a large bag of trash located in room A2.

On 7/22/2025 at 2:20 pm, there was dried fecal matter along the outside of the toilet bowl in the bathroom for Room [redacted].

Plan of Correction ***Accept [redacted] - 08/26/2025)***

This regulation is important because clean and sanitary conditions prevent infection, promote dignity, and ensure

85a - Sanitary Conditions (continued)

residents live in a safe environment. Housekeeping staff cleaned the affected areas immediately on 7/22/2025.? On August 18th staff members received additional training in housekeeping, conflict resolution, and resident care engagement.? Starting August 18th, housekeeping was increased in high-use areas, with weekly audits conducted by the Administrator.?This will continue for one month, unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *08/22/2025*

Implemented (- 10/30/2025)

85b - Infestation

11. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 7/22/2025 at approximately 3:20 pm, a mouse was observed running through the dining area.

On 7/23/2025, multiple flies were observed flying around the home and flying around residents during interviews. Residents were observed swatting flies away from their faces.

Repeat Violation: 11/6/24 et al, 8/7/24 et al.

Plan of Correction ***Accept - 08/26/2025)***

This regulation is important because pest-free conditions protect resident health, prevent contamination, and maintain a safe and sanitary living environment.
On 7/23/2025, the facility immediately engaged pest control services, placed rodent boxes, and instructed staff to maintain cleanliness in high-traffic areas.
Also on 7/23/25, additional pest control measures were implemented, including daily dining room cleaning, increased housekeeping routines, and a staff directive to keep doors closed.?Monitoring: Starting September 1st, pest control reports will be reviewed monthly by the Administrator, and housekeeping staff will log weekly sanitation compliance. This will last for one month unless an extension is found to be necessary.?

Licensee's Proposed Overall Completion Date: *08/22/2025*

Implemented - 10/30/2025)

88a - Surfaces

12. 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 7/22/2025, there were two railings along the side of the wall that were located outside room B9 and B16 that were loose and coming off the walls.

On 7/22/2025, The ceiling in the basement's storage room had a leak that caused a collapse and was currently leaking onto the floor with a large amount of water. There was a hole in ceiling and it was actively leaking.

88a - Surfaces (continued)

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Immediate action was taken by the administrator scheduling maintenance to complete repairs by September 1st. Repairs to the railings and basement ceiling have been scheduled and will be completed by September 1st. Maintenance staffing has been increased as of August 18th with the addition of new housekeepers/maintenance personnel to ensure timely repairs. Starting September 5th, the Administrator will conduct weekly walkthroughs to identify and correct potential hazards. Walkthroughs will continue for one month unless an extension is found to be necessary.

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

Implemented [redacted] - 10/30/2025)

100a - Exterior - Free of Hazards

13. 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 7/22/2025, there was poison oak growing around the perimeter of the home's designated smoking area.

On 7/22/2025, the safety fencing for the fire escape balcony outside the second floor exit was detached.

Plan of Correction ***Accept [redacted] - 08/26/2025)***

This regulation is important because maintaining exterior grounds free of hazards ensures safe access for residents, visitors, and staff.
The poison oak was removed immediately on 7/22/2025. Fire escape fencing repairs were initiated and will be completed by the end of August 2025.? Landscaping contractor has been instructed to monitor grounds weekly starting 8/25/25.?Starting 8/25/25, exterior inspections will be logged and reviewed monthly by the Administrator.? This will continue for three months unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *08/24/2025*

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

101j3 - Bed/Linens/Pillows/Blankets

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The bed for resident 7 has bed sheets that are soiled and have yellow and brown stains.

Repeat violation: 11/6/24 et al, 8/7/2024 et al

Plan of Correction ***Accept [redacted] - 08/26/2025)***

This regulation is important because clean and undamaged linens promote hygiene, dignity, and comfort for

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

residents. The stained linens were discarded and replaced on 7/23/25.?Residents will be redirected to bathrooms for hair dye application to prevent damage to bedding. Starting 8/25/25, housekeeping staff will conduct weekly linen checks and report issues to the Administrator.?This will continue for one month unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *08/24/2025*

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

101j7 - Lighting/Operable Lamp

15. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 7 does not have access to a source of light that can be turned on/off at bedside.

Resident 8 does not have access to a source of light that can be turned on/off at bedside.

Repeat violation: 11/6/24 et al, 8/7/2024 et al

Plan of Correction ***Accept [redacted] - 09/04/2025)***

This regulation is important because accessible lighting is necessary for resident safety, mobility, and independence. Operable lamps were retrieved from supply and installed in resident rooms on August 1st. A routine supply review starting September 5th will ensure adequate stock of replacement lamps. Housekeeping will confirm operable bedside lighting in weekly room checks starting September 5th. This will last for one month unless an extension is found to be necessary.

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

Not Implemented [redacted] 10/30/2025)

102i - Soap Dispenser

17. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 7/22/2025, There was an empty soap dispenser located in the common bathroom next to the elevator located on the third floor of the home. This bathroom was for resident use.

Plan of Correction ***Accept [redacted] - 08/26/2025)***

This regulation is important because soap dispensers must be maintained to support infection control and resident hygiene. The dispenser was replaced and restocked on 7/23/2025.?Housekeeping staff (led by [redacted]) will check all soap dispensers daily and restock as needed starting 7/23/2025. Starting on August 1st, housekeeping supervisor will conduct weekly checks of supplies.?This process will continue for one month, unless an extension is found to be necessary.

102i - Soap Dispenser *(continued)*

Licensee's Proposed Overall Completion Date: *08/22/2025*

Implemented [redacted] - 10/30/2025)

105g - Lint Removal and Duct Cleaning

18. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 7/22/2025, there was an approximate 1 inch accumulation of lint in the lint trap of the home's dryer. There were no clothes in the dryer at the time.

Plan of Correction ***Accept [redacted]E - 08/26/2025)***

This regulation is important because lint accumulation is a serious fire hazard and must be removed after each dryer use. Dryer lint trap was cleared immediately on 7/22/2025.?All staff received training on August 18th about the dangers of lint accumulation. Dryer lint traps will be checked weekly by housekeeping. Logs will be maintained for one month, unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *08/22/2025*

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

107b - Emergency Procedures

19. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:
1. Contact information for each resident's designated person.

Description of Violation

The home's written emergency procedures do not include contact information for each resident's designated person.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Immediate action was taken by the Administrator reviewing the current Emergency Management Plan on 7/23/25 and determining that updates were necessary. Updates were made by the administrator and finalized August 30th, 2025.
Starting September 5th, the Administrator will ensure monthly EMP audits. This process will continue for 3 months, unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *08/28/2025*

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

107d - Procedure Emergency Management Agency Submission

20. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

107d - Procedure Emergency Management Agency Submission *(continued)*

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency.

Plan of Correction ***Accept [redacted] 09/04/2025)***

Immediate action was taken by the administrator reviewing the emergency procedures on 7/23/25 and determining that they had not been sent in.
The EMP will be resent by the administrator and confirmation obtained from EMA on or before September 5th.
Preventive action: Starting September 5th, the Administrator will contact EMA weekly for 1 month to ensure receipt and maintain documentation. EMP submissions will be reviewed monthly by the administrator starting 9/5/25. This will last for three months unless an extension is found to be necessary.

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

Implemented [redacted] - 10/30/2025)

123c - Evacuation Diagrams

21. Requirements

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 61 residents. However, the home's evacuation diagrams do not include the location of fire extinguishers or the line of travel to evacuate.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Immediate action was taken by the administrator reviewing the evacuation diagrams and determining they needed to be updated. On or before September 5th, an inspector/consultant will be contacted to provide updated diagrams for the personal care home. New diagrams will be put in place by September 12th. Starting September 12th, direct care staff will monitor the diagrams on a weekly basis for one month to ensure ongoing compliance.

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

Implemented [redacted] - 10/30/2025)

124 - Notice to Fire Department

22. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

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

Plan of Correction ***Accept ([redacted] - 09/04/2025)***

Immediate action was taken by the administrator contacting the fire department August 15th to request a new form to be completed and sent in. On August 20th, a new notification letter was sent to the fire department with documentation kept on file. Documentation of all fire department notifications will be maintained by the

124 - Notice to Fire Department (continued)

Administrator starting September 5th. Annual audits will confirm documentation is up to date.

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

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

131f - Fire Extinguisher Inspection

23. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in located near room B11 has not been inspected by a fire safety expert since February 2024.

The fire extinguisher in located in the laundry room has not been inspected by a fire safety expert since January 2024.

There were two other fire extinguishers, one located near the nurse office on the first floor and on the second floor of the home near the emergency exit that were missing annual inspection tags.

Repeat violation: 11/6/24 et al

Plan of Correction ***Accept[redacted] - 09/04/2025)***

Immediate action was taken by the administrator on August 1st by checking all fire extinguishers in the building and making a note of which ones needed inspection and tagging.
Fire extinguishers have been scheduled for inspection and tagging by a certified fire safety vendor to be completed by September 12th. On or before September 5th, extinguishers will be added to the facility's maintenance calendar for annual inspection scheduling. Starting September 12th, the administrator will verify inspection tags monthly for three months unless an extension is found to be necessary.

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

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

132b - Safety Inspection/Fire Drill

24. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and drill observed by a fire safety expert was conducted on 1/18/2024.

Plan of Correction ***Accept[redacted] - 09/04/2025)***

Immediate action was taken by the administrator reviewing the home's fire safety logs on 7/23/25.
On or before September 5th, the administrator will schedule a new monitored fire drill and inspection to take place within the month of September. The administrator will ensure that monitored drills and inspections take place

132b - Safety Inspection/Fire Drill (continued)

annually starting September 5th, 2025. Starting 9/5/25, the administrator will maintain documentation of all fire drills and inspections and will review them monthly for 3 months.

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

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

132g - Fire Drills Days/Times

25. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills at the end of the month as evidenced by the following drills 10/31/2024 at 5:18 pm, 11/29/2024 at 6:05 am, 12/31/2024 at 3:02 pm, 01/31/2025 at 12:00 pm, 2/28/2025 at 10:21 pm, 3/27/2025 at 12:06 am.

Plan of Correction ***Accepti[redacted] - 09/04/2025)***

Immediate action was taken by the administrator reviewing the fire drill logs 7/23/25 and determining to change the dates that future drills are conducted. A new drill calendar will be developed by the administrator to vary times and days by September 5th. Fire drills will be randomized throughout the year. On or before September 5th, the Administrator will maintain a "tickler calendar" to ensure variation of all drills. Fire drill logs will be monitored monthly starting September 5th for three months by the administrator.

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

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

141a 1-10 Medical Evaluation Information

26. 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. 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.
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.

Description of Violation

Resident 4's medical evaluation did not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

141a 1-10 Medical Evaluation Information *(continued)*

Plan of Correction ***Accept[redacted] - 09/04/2025)***

Immediate action was taken by the administrator contacting the Resident's physician on August 1st to request additional evaluation components. The resident's physician will complete missing evaluation components by September 5th. Starting September 5th, the Administrator will ensure all evaluations are complete before admission files are finalized. Starting September 5th, the administrator will conduct monthly audits of resident files for three months to confirm completeness.

Licensee's Proposed Overall Completion Date: *08/28/2025*

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

162c - Menus Posted

27. Requirements

2600.
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 home's menu for the week of 7/20/2025 was blurry and unable to be read by residents. The menu for the week in advance was not posted.

Plan of Correction ***Accept[redacted] - 08/26/2025)***

This regulation is important because menus must be legible and posted in advance to ensure residents know meal options and the facility provides balanced nutrition. Menu was updated and reposted in a clear format on 7/24/25.? Preventive action: Starting September 1st, changes will be posted on a wall-mounted dry-erase board to prevent overlap. Housekeeping and kitchen staff will check menu postings weekly starting September 1st.?This process will continue for one month, unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *08/22/2025*

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

183b - Meds and Syringes Locked

28. Requirements

2600.
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 room.

Description of Violation

On 7/22/2025 at 2:30 pm, Saline Spray and Fluticasone spray was unlocked, unattended, and accessible in room [redacted]

Plan of Correction ***Accept[redacted] - 09/04/2025)***

This regulation is important because medications and syringes must be locked to prevent unauthorized access and protect resident safety.
Items were removed and secured on 7/22/25. On August 18th, Staff received redirection/conflict resolution

183b - Meds and Syringes Locked (continued)

training, along with reinforcement of medication storage requirements. Rooms will be checked daily starting September 5th for unlocked medication by direct care staff. Daily checks will last for one month unless an extension is necessary.

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

Implemented (- 10/30/2025)

185a - Implement Storage Procedures

29. 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

On 7/23/2025 at 8:00 am, Resident 9's glucometer had a blood sugar reading of 134 but the reading was documented on the Medication Administration Record as 132.

Plan of Correction ***Accept - 09/04/2025)***

Immediate action was taken by the medication supervisor on August 1st by scheduling staff education on reading glucose meters. Staff members were educated on correctly reading glucose meters on August 18th. All staff administering medications will receive retraining on accurate documentation before September 5th. Starting 9/5/25, the Administrator will audit MARs weekly for accuracy. These audits will last one month unless an extension is necessary.

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

Not Implemented - 10/30/2025)

30. 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 10 is prescribed Acetaminophen 325mg as needed. On 7/23/2025 this medication was not available in the home.

Repeat violation: 11/6/24 et al

Plan of Correction ***Accept - 09/04/2025)***

This regulation is important because required medications must be readily available to meet resident medical needs. Medication was delivered the same day on 7/23/25. Starting September 5th all pharmacy delays will be logged by the medication supervisor; Administrator will confirm delivery for all PRN orders. Weekly audits of medication stock will be conducted by the medication supervisor starting September 5th. These audits will last for one month unless an extension is necessary.

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

Not Implemented 10/30/2025)

190a - Completion Medication Course

31. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:
On 7/2/2025 at 9:00 am, Lisinopril 40mg to Resident 9
On 7/9/2025 at 9:00 am, Lisinopril 40mg to Resident 9
On 7/16/2025 at 9:00 am, Lisinopril 40mg to Resident 9
This staff person's most recent annual practicum was completed 5/6/24.

Staff person D, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:
On 7/6/2025 at 9:00 am, Lisinopril 40mg to Resident 9
On 7/13/2025 at 9:00 am, Lisinopril 40mg to Resident 9
On 7/20/2025 at 9:00 am, Lisinopril 40mg to Resident 9
This staff person's most recent annual practicum was completed 5/6/24.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Staff were certified by the med trainer immediately following inspection on 7/23/25. The observation plan is a course designed to prepare staff to be observers who can assist in certifying other staff when the Administrator/Med Trainer is unavailable. Staff will complete this observer preparation course to support future certifications on or before September 5th. Starting 9/5/25, the Administrator will confirm course completion on a monthly basis and maintain certification records. Monthly confirmations will last 3 months unless an extension is found to be necessary.

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

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

190b - Insulin Injections

32. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 7/2/2025 at 9:00 am, staff person C, who has not successfully completed the Department-approved medications administration course, administered insulin to resident 9.

On 7/6/2025 at 9:00 am, staff person D, who has not successfully completed the Department-approved medications administration course, administered insulin to resident 9.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Staff were certified by the med trainer immediately following inspection on 7/23/25. The observation plan is a course designed to prepare staff to be observers who can assist in certifying other staff when the Administrator/Med Trainer is unavailable. Staff will complete this observer preparation course to support future certifications on or before

190b - Insulin Injections (continued)

September 5th. Starting 9/5/25 the Administrator will confirm course completion on a monthly basis and maintain certification records. Monthly confirmations will last 3 months unless an extension is found to be necessary.

Proposed Overall Completion Date: 09/05/2025

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

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

225a - Assessment 15 Days

34. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 11 was admitted on [redacted]/2025; however, the resident's assessment was not completed until [redacted]12/2025 and is incomplete for the resident's medical diagnosis of Parkinsons.

Plan of Correction ***Accept [redacted] - 09/04/2025)***

Resident #11's rasp was updated on August 22nd to reflect that she has Parkinsons. Resident #11's assessment was updated on 7/23/2025 with complete medical information. The Administrator will complete re-education training to improve assessment compliance by the end of September 2025. Starting September 5th, assessments will be reviewed monthly by the administrator for timeliness and completeness. This will continue for 3 months unless an extension is found to be necessary.

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

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

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

Facility Information

Name: *VINE STREET MANOR* **License #**: *14234* **License Expiration**: *04/18/2026*

Address: *230 NORTH 65TH STREET, PHILADELPHIA, PA 19139*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *KAYMARIE BRIDDELL*

Address: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *09/07/2018* **Issued By**: *City of Philadelphia*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *66* **Waking Staff**: *50*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *09/25/2025*

Inspection Dates and Department Representative

09/25/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served**: *62*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *48* **Are 60 Years of Age or Older**: *47*

Diagnosed with Mental Illness: *32* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *4* **Have Physical Disability**: *0*

Inspections / Reviews

09/25/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/01/2025*

10/31/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/05/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/07/2025*

11/17/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/05/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted]/2025, for resident 1 was not signed by the payer, who is not the resident

Plan of Correction ***Accept ([redacted]S - 10/30/2025)***

Immediate action was taken by the administrator contacting the payer for resident #1. On October 1st the home was able to obtain the required signature on the resident-home contract. The updated contract has been placed in the resident's file. Going forward, all new resident-home contracts will be reviewed by the Administrator at the time of admission to confirm all required signatures are present before the resident moves in. Starting October 19th, the administrator will conduct weekly audits of all resident contracts to ensure compliance. Audits will continue for one month unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *11/02/2025*

Not Implemented [redacted] - 11/17/2025)

42b - Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 9/17/2025 at approximately 6:22 PM, resident 2 knocked on resident 3's door. When resident 3 opened [redacted] door resident 2 punched [redacted] on the left upper side of the head, causing resident 3 to fall down. Resident 2 then walked away from Resident 3.

Resident 3 reported the physical attack by Resident 2, to staff persons A and B, who called 911 and sent resident 2 out to the hospital. Resident 3 returned to the home with a large brown/yellow bruise on [redacted] head that was still visible to an agent of the Department on 9/25/2025. Resident 2 admitted to hitting resident 3 but gave no reason for attacking Resident 3 other than to say they do not like Resident 3.

Resident 2 is diagnosed with schizophrenia and psychosis. Resident 2's most recent assessment was completed on 9/30/2024 and indicated [redacted] was verbally aggressive, but not physically aggressive, towards other residents, had no problems with irritability, judgement, or hallucinations. The resident was assessed to have minimal to no agitation. Under the needs related to aggression, residents RASP shows "Resident has periods of profanity and attitude".

Resident 3 reported that Resident 2 had been calling [redacted] "bozo" and "clown" in the months prior to the incident and that [redacted] had informed staff of this multiple times including the day prior to the physical attack on 9/17/25. Resident 3's concerns and fears were not documented by the home, instead, both residents were just told to avoid each other in the home. Resident 3 is now scared to leave [redacted] room and is only leaving their room to use the toilet. Resident 3 did not shower for 3 days because [redacted] was in fear of "being jumped" by resident 2.

Repeat Violation Date: 11/6/24 et al.

42b - Abuse (continued)

Plan of Correction ***Accept [redacted] - 10/30/2025)***

On 9/17/2025, staff immediately intervened by contacting 911 and ensuring both residents received appropriate medical attention. Resident #3 was sent to the hospital and did not return until cleared by medical professionals. When resident #3 returned to the home, staff members closely monitored both residents involved in the incident. Residents #2 and #3 were checked on regularly to ensure no additional altercation took place. Residents were kept separate from each other in an effort to prevent another incident. Staff members have been using the home's communication app to report checks and updates on both residents during all shifts.
Resident #2's RASP has been updated to include interventions for both verbal and physical aggression. On October 22nd, staff members will receive retraining on proper documentation and reporting of resident-to-resident conflicts, including verbal intimidation, and on the importance of prompt intervention and notification of the Administrator. Going forward, all resident-reported concerns regarding verbal harassment, intimidation, or conflict will be documented on the residents' ecp log and reported to the Administrator immediately for review and follow-up. Starting October 22nd, the administrator will review residents' RASPs once a month for three months to ensure all support plans remain current.

Licensee's Proposed Overall Completion Date: *11/02/2025*

Not Implemented [redacted] - 11/17/2025)

65e - 12 Hours Annual Training

3. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person B received only 8 hours of annual training in training year 1/1/2024-12/31/2024.

Plan of Correction ***Accept [redacted] - 10/30/2025)***

On October 1st, immediate action was taken by the administrator reviewing all staff training records for 2024 to ensure compliance. Not all certificates for training include the duration for each training session. Due to the fact that all trainings lasted 2 hours, staff member B did in fact have 12 hours of training during the 2024 training year. We request that this violation be removed.
Going forward, the administrator will ensure that each training certificate properly states how long each training session lasts to prevent confusion. Starting October 22nd, staff training records will be reviewed on a monthly basis by the administrator to ensure compliance. Reviews will continue for three months.

Licensee's Proposed Overall Completion Date: *11/02/2025*

Not Implemented [redacted] - 11/17/2025)

65f - Training Topics

4. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.

65f - Training Topics *(continued)*

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

Direct care staff person B did not receive training in medication self-administration training and safe management techniques during training year 1/1/2024-12/31/2024.

Plan of Correction ***Accept [redacted] - 10/31/2025)***

The Administrator reviewed all staff training records on October 1st. On August 9th, 2024, staff person B completed training in Safe Management Techniques. Please see attached. We ask that this violation be removed.
A training checklist will be developed by October 22nd, 2025 that will list all required annual training topics, including medication self-administration. This checklist will be updated as trainings are completed. Starting October 22nd, staff training records will be reviewed on a monthly basis by the administrator to ensure compliance. Reviews will continue for three months.

Licensee's Proposed Overall Completion Date: *11/02/2025*

Not Implemented [redacted] - 11/17/2025)

65i - Training Record

5. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training for staff person B does not include the length of the trainings for Tristate fire safety and shelter in place, care for residents with dementia and cognitive impairments, and emergency preparedness.

Plan of Correction ***Accept [redacted]S - 10/31/2025)***

The Administrator reviewed all staff training records on October 1st. On October 19th, the Administrator updated staff person B's training record to include the length of each training session. The updated documentation now meets regulatory requirements. By October 22nd, a training record template will be created to ensure all future trainings include every required element, including course length. Starting October 22nd, staff training records will be reviewed on a monthly basis by the administrator to ensure compliance. Reviews will continue for three months.

Licensee's Proposed Overall Completion Date: *11/02/2025*

Not Implemented [redacted] - 11/17/2025)

100a - Exterior - Free of Hazards

6. Requirements

100a - Exterior - Free of Hazards *(continued)*

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

The step in front of the exit in the back dining area is cracked and degrading creating tripping hazard.

Plan of Correction ***Accept [redacted] - 10/31/2025)***

Immediate action was taken by placing a caution sign and temporary barrier around the tripping hazard on 9/25/2025. On October 12th, the home hired an outside handyman to repair the cracked step. The step is now level, secure and free of cracks. On October 19th, maintenance staff members were told to complete weekly exterior inspections of all exit areas, steps and walkways to identify and address any potential hazards promptly. Any hazards are to be reported immediately via the groupme chat. Weekly inspections will continue for one month unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *11/02/2025*

Not Implemented ([redacted] - 11/17/2025)

131f - Fire Extinguisher Inspection

7. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher hanging next to the nursing station's door does not have a tag showing it has been inspected by a fire safety expert.

Repeat Violation Date: 11/6/24 et al.

Plan of Correction ***Accept ([redacted] - 10/31/2025)***

On 10/01/25 action was taken by inspecting all of the home's fire extinguishers. On September 30th a fire expert came out to re-inspect and re-tag the extinguisher by the nursing station. However, we ask that this violation be removed due to the fact that the extinguisher had been previously inspected in January of 2025.
The tag had been removed by a resident of the home who suffers from a mental health illness. Please see attached proof of service. Starting October 19th, maintenance staff will conduct walkthroughs to check that each fire extinguisher still has the service tag in place. Weekly walkthroughs will continue for one month.

Licensee's Proposed Overall Completion Date: *11/02/2025*

Not Implemented [redacted] - 11/17/2025)

141a 1-10 Medical Evaluation Information

8. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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.
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.

Description of Violation

Resident 2's medical evaluation, dated [redacted] 2025, did not include medication regimen, contraindicated medications, and medication side effects.

Resident's 3's medical evaluation, dated [redacted]/2025, did not include medication regimen, contraindicated medications, and medication side effects.

Plan of Correction ***Accept [redacted] - 10/31/2025)***

On October 1st, action was taken by contacting both resident's PCP to request new DME's to be filled out in their entirety. New medical evaluations will be received and put in the resident's files by October 31st, 2025. Going forward, the administrator will review all new and annual medical evaluations upon receipt to ensure all required areas are fully completed. If any section is incomplete, the form will be returned to the healthcare provider for correction before being filed. Starting November 1st, a quarterly audit of all medical evaluations will be conducted to ensure ongoing compliance. Quarterly audits will continue for one year by the administrator.

Licensee's Proposed Overall Completion Date: *11/01/2025*

Not Implemented [redacted] - 11/17/2025)

183d - Prescription Current

9. 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

On 9/25/2025, a bottle of acetaminophen 500 mg belonging to resident 3 was in the home's medication cart; however, the resident does not have an order for this medication. The resident's medication administration record for Sept 2025 has an order for Acetaminophen 325mg- take 3 tablets by mouth every 8 hours as needed for pain- ordered on 1/11/25.

Plan of Correction ***Accept [redacted] - 10/31/2025)***

Resident #3 does have an order for 500mg that came in the same day as the inspection. Resident #3 also has an order for 325mg. [redacted] is very involved in [redacted] medication needs and contacted [redacted] doctor to prescribe the 500mg without letting the facility know.
On October 6th, the home's medication cart was audited by the med tech to confirm that only medications with current physician orders are stored in the home. No additional discrepancies were found. Starting October 27th, The Medication Technician will conduct weekly medication audits for four weeks to verify that all medications stored in

183d - Prescription Current (continued)

the home are current and match the physician's orders.

Licensee's Proposed Overall Completion Date: *11/02/2025*

Not Implemented [redacted] - 11/17/2025)

190c - Record of Training

10. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person A does not include documentation of successful completion of their initial online certification training. The date of this certification training is unknown.

Plan of Correction ***Accept [redacted] - 10/31/2025)***

Staff person A retook the initial online training course on October 19, 2025. Staff person A had previously completed the course but was unable to retrieve the information at the time of the inspection. Starting October 22nd, staff training records will be reviewed on a monthly basis by the administrator to ensure compliance. Reviews will continue for three months. Any missing or incomplete records identified during the reviews will be corrected immediately.

Licensee's Proposed Overall Completion Date: *11/02/2025*

Not Implemented [redacted] - 11/17/2025)

[redacted]

201 - Positive Interventions (continued)

aggression. Monthly RASP reviews will continue for 3 months by the administrator.

Licensee's Proposed Overall Completion Date: *11/02/2025* **Withdrawn- MS-1/6/26**

Not Implemented (MS - 11/17/2025)

225c - Additional Assessment

12. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 2 is diagnosed with schizophrenia and psychosis. Resident 2's most recent assessment, completed on [redacted] 2024, indicated [redacted] was verbally but not physically aggressive towards other residents, had no problems with irritability, judgment, or hallucinations. The resident was assessed to have minimal to no agitation. Under the needs related to aggression, the resident's RASP indicates "Resident has periods of profanity and attitude".

On 9/17/2025 Resident 2 struck Resident 3 in the side of the head. Resident 3 reported Resident 2 had been calling [redacted] names for months prior to the incident.

When Resident 2 was interviewed on [redacted]25/25 by an agent of the Department, [redacted]e reported [redacted] hit Resident 3 and provided no reasoning, then said people come in [redacted] room at night, walking through the walls and resident began talking nonsensically about shadows that are coming to get[redacted], indicating that the resident is possibly experiencing hallucinations.

The home has not re-evaluated Resident 2 since the incident where the resident displayed physical aggressions, and has not been reassessed for a significant change in behavioral needs, though resident has shown significant changes since their last assessment. Repeat Violation Date: 11/6/24 et al.

Plan of Correction ***Accept [redacted] - 10/31/2025)***

On October 19, 2025, the Administrator completed a new assessment for resident #2 to reflect current behavioral. and psychiatric needs. Staff members have been instructed to immediately report and document any changes in resident behavior or condition to an administrator. On October 22, 2025, staff will receive retraining on identifying and reporting behavioral or health changes that may require can updated assessment. Starting October 22, the administrator will review all documented behavioral changes and incidents on a weekly basis for one month. Resident assessments will be reviewed monthly starting October 22nd to ensure they remain accurate and reflective of each resident's current needs. Reviews will last for three months unless an extension is found to be necessary.

Licensee's Proposed Overall Completion Date: *11/02/2025*

Not Implemented [redacted] - 11/17/2025)

[redacted]