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

January 20, 2026

[redacted]
THREE READING, LP
[redacted]
C/O HERITAGE SENIOR LIVING
[redacted]

RE: THE MANOR AT MARKET SQUARE
803 PENN STREET
READING, PA, 19601
LICENSE/COC#: 20589

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/08/2025, 10/14/2025 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: *THE MANOR AT MARKET SQUARE* **License #**: *20589* **License Expiration**: *10/20/2026*

Address: *803 PENN STREET, READING, PA 19601*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *THREE READING, LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/01/2000* **Issued By**: *L&I*

Type: *Other* **Date**: *08/01/2000* **Issued By**: *City of Reading*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *103* **Waking Staff**: *77*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *10/14/2025*

Inspection Dates and Department Representative

10/08/2025 - On-Site: [redacted]

10/14/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak Neighborhood* **Capacity**: *18* **Residents Served**: *15*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *71*

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

Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

10/08/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/07/2025*

Inspections / Reviews *(continued)*

11/24/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *12/01/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/01/2025*

01/20/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/01/2025*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident [redacted] is prescribed [redacted] and [redacted]-unit caplets. However, Resident [redacted] was not administered the medication on the afternoon of [redacted] as the resident was out of the home without medications. The home did not report the medication error to the Department.

Resident [redacted] has an order for [redacted] tablets to be administered twice daily at 8:00 a.m. and 8:00 p.m. The resident was not administered the medication on [redacted] at 8:00 pm as the resident was out of the home without medication. The home did not report the medication error to the Department.

Plan of Correction ***Accept [redacted] - 11/20/2025)***

Immediate Corrective Action: The Executive Director reported the incident to DHS on 10/10/2025.

Additional Corrective Action: Staff were educated on 10/16/2025 by the Executive Director that all medication errors be immediately reported to DHS. Beginning 10/9/2025 The Resident Care Director will review the clinical dashboard daily as a way to monitor missed medications and any other issues that may occur.

Ongoing Quality Assurance Actions: Beginning on 10/9/2025 The Resident Care Director and Clinical Care Coordinator will monitor all medication errors to ensure that they are being reported to the department as outlined in the PCH Regulations. Incidents are reviewed at daily clinical meetings and our quarterly QA meeting to follow up and ensure that incidents are reported timely and accurately. This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review of Q4 2025 (October, November, December)

Proposed Overall Completion Date: 11/28/2025

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

Implemented [redacted] - 01/20/2026)

25b - Contract Signatures

2. Requirements

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

Description of Violation

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

25b Contract Signatures *(continued)*

Plan of Correction ***Accept [redacted] - 11/24/2025)***

Immediate Corrective Action: Resident [redacted] refused to sign resident agreement when asked by the Executive Director on 10/9/2025

Additional Corrective Action: The Executive Director was educated on 10/8/2025 by DHS Dept Representative Megan Baronitis that contracts need to be signed by the resident or refusal need to be documented.

Ongoing Quality Assurance Actions: Beginning on 11/4/2025 the Executive Director will audit 5% sample of resident records by using our "30 day chart audit tool" to ensure that signatures are present by 11/28/2025, once audit is complete, they will continue to be ongoing. This will be reviewed as part of the quarterly QA meeting to ensure ongoing compliance, beginning January 2026 for review of Q4 2025 (October, November, December)

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

Implemented ([redacted] - 12/08/2025)

64a - Admin Training

3. Requirements

2600.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
1. An orientation program approved and administered by the Department.
3. A Department-approved competency-based training test with a passing score.

Description of Violation

Staff person A, who is the home's administrator, has not successfully completed the orientation program approved and administered by the Department and the Department approved competency based training test.

Plan of Correction ***Accept [redacted] - 11/24/2025)***

Immediate Corrective Action: Staff member A completed the Department approved competency based training exam through Penn State University Abington Campus and successfully passed on 10/23/2025

Additional Corrective Action: Staff member A is registered and will complete the DHS orientation on November 21st, 2025.

Ongoing Quality Assurance Actions: The Executive Director will review the binder monthly to ensure that Staff A documentation is available for review. This will be reviewed as part of the quarterly QA meeting to ensure ongoing compliance, beginning in January 2026 for review of Q4 2025 (October, November, December)

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

Implemented ([redacted] - 12/08/2025)

85a - Sanitary Conditions

4. Requirements

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

85a - Sanitary Conditions *(continued)*

Description of Violation

At approximately 4:36 p.m. in room [redacted] bathroom, the bathmat in the shower had orange stains and a black substance on the underside around the suction cups.

Plan of Correction ***Accept[redacted] 11/24/2025)***

Immediate Corrective Action: A new bathmat was ordered by the Business Office Director on 10/9/2025 for room [redacted].

Additional Corrective Action: The housekeeping staff was educated on 10/9/2025 by the Executive Director that if they notice or have any sanitary concerns on resident apartments to notify their supervisor so it can be replaced.

Ongoing Quality Assurance Actions: The Executive Director will audit apartments weekly with our "apartment turnover checklist" to ensure sanitary conditions are maintained. This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for Q4 2025 (October, November, December)

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

Implemented[redacted] - 12/08/2025)

101j7 - Lighting/Operable Lamp

5. 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[redacted] does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] - 11/24/2025)***

Immediate Corrective Action: A source of lighting was installed at resident [redacted] bedside on 10/9/2025 by the Maintenance Assistance.

Additional Corrective Action: The Maintenance Assistant was educated on 10/9/2025 by the Executive Director that residents need to have a source of lighting and within reach at bedside.

Ongoing Quality Assurance Actions: The Executive Director will audit apartments weekly with our "apartment turnover checklist" to ensure each resident has a light within reach of bed. This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for Q4 2025 (October, November, December)

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

Implemented ([redacted] - 01/20/2026)

103e - Left Overs

6. Requirements

2600.

103e - Left Overs *(continued)*

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

At approximately 2:40 p.m. there were 3 packs of American cheese and an opened bag of broccoli in the kitchen refrigerator and 18 loaves of bread in the storage area of the kitchen that were unlabeled and undated.

Repeat violation: [redacted] *et al*

Plan of Correction ***Accept ([redacted] - 11/24/2025)***

Immediate Corrective Action: All expired and improperly labeled food has been removed by the Dietary Services Director and discarded on 10/8/2025. No residents were affected.

Additional Corrective Action: The Dietary staff were educated by the Dietary Services Director on labeling and dating procedures on 10/9/2025.

Ongoing Quality Assurance Actions: Beginning 10/9/2025 the Dietary Services Director will monitor and audit food and beverage for proper labeling and dating daily by using the "Kitchen Cleaning Checklist". This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review of Q4 2025 (October, November, December)

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

Implemented [redacted] - 12/08/2025)

103g - Storing Food

7. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At approximately 2:50 p.m., in the kitchen storage area a container of chocolate chips was opened and unsealed.

Plan of Correction ***Accept [redacted] - 11/24/2025)***

Immediate Corrective Action: The Dietary Services Director placed the chocolate chips into a sealed container on 10/8/2025.

Additional Corrective Action: The dietary staff were educated by the Dietary Services Director on proper kitchen storage on 10/9/2025.

Ongoing Quality Assurance Actions: Beginning 10/9/2025 the Dietary Services Director will monitor and audit food and beverage items being properly stored daily by using the "kitchen cleaning checklist. This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review of Q4 2025 (October, November, and December).

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

Implemented [redacted] - 12/08/2025)

103i Outdated Food

8. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At approximately 2:47 p.m. there was a pack of 12 hot dog buns located in the kitchen storage area that appeared to have a green, furry substance on the bottom 6 hot dog buns.

Plan of Correction ***Accept (- 11/24/2025)***

Immediate Corrective Action: The Dietary Services Director removed and discarded the hotdog buns on 10/8/2025.

Additional Corrective Action: The dietary staff were educated by the Dietary Services Director on outdated/spoiled food on 10/9/2025.

Ongoing Quality Assurance Actions: Beginning 10/9/2025 the Dietary Services Director will monitor and audit all food and beverage to ensure items are not outdated or spoiled by using the "Kitchen Cleaning Checklist". This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review of Q4 2025 (October, November, December)

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

Implemented 12/08/2025)

107d Procedure Emergency Management Agency Submission

9. Requirements

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

Description of Violation

The home's written emergency procedures were last submitted to the local emergency management agency on and the previous submission was on

Plan of Correction ***Accept - 11/24/2025)***

Immediate Corrective Action: The Executive Director immediately submitted the home's written emergency procedures on 10/8/2025.

Additional Corrective Action: The Executive Director was educated by DHS department representative Jennie Heinberg, on 10/8/2025 that the homes written emergency procedures need to be submitted to the local emergency management agency annually.

Ongoing Quality Assurance Actions: This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review of Q4 2025 (October, November, December)

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

Implemented - 12/08/2025)

132a - Monthly Fire Drill

10. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of March 2025 and August 2025.

Plan of Correction ***Accept [redacted] - 11/24/2025)***

Immediate Corrective Action: The Director of Maintenance and Maintenance Assistant will ensure that fire drills are occurring monthly starting 10/8/2025

Additional Corrective Action: Starting 10/9/2025 the Executive Director will review the TELS system weekly to ensure that fire drills are completed monthly.

Ongoing Quality Assurance Actions: Utilizing our TELS system, the Maintenance Director will ensure that our monthly fire drills occur. The Executive Director will check the use of the TELS system and the documentation of fire drills. This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review of Q4 2025 (October, November, December).

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

Implemented [redacted] - 12/08/2025)

132c - Fire Drill Records

11. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on [redacted] at 11:15 p.m. noted no evacuation required. However, the homes fire drill log noted 108 residents were in the home and evacuated. The fire drill logs are not documented correctly.

Plan of Correction ***Accept [redacted] - 11/24/2025)***

Immediate Corrective Action: The Maintenance Assistant was educated on 10/9/2025 that the fire drill records need to be documented properly per PCH requirements.

Additional Corrective Action: The Executive Director will review monthly fire drills starting 10/31/2025 to ensure that the documentation is correct.

Ongoing Quality Assurance Actions: The Executive Director will work closely with the Maintenance Director and Maintenance Assistant in reviewing fire drill documentation. This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review Q4 2025 (October, November, December)

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

132c Fire Drill Records *(continued)*

Implemented (12/08/2025)

132f Alternate Exit Routes

12. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The common areas was noted on the fire drill logs as the only exit route used during the fire drills held on , and .

Plan of Correction ***Accept (- 11/24/2025)***

Immediate Corrective Action: A fire drill was conducted on 10/31/2025 by the Maintenance Assistant using alternate exit routes.

Additional Corrective Action: The Executive Director will complete education with staff by 11/24/2025 to ensure that they are using alternate exit routes depending on where the fire is occurring.

Ongoing Quality Assurance Actions: The Executive Director will work closely with the Maintenance Director and Maintenance Assistant in reviewing fire drill documentation. This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review Q4 2025 (October, November, December)

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

Implemented - 12/08/2025)

144c1 Smoking Area Guidelines

13. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home permit's smoking in a designated smoking area in the rear of the home. At 10:00 a.m. 6 cigarette butts were noted in the mulch bordering the parking lot in the rear area of the home.

Plan of Correction ***Accept 11/24/2025)***

Immediate Corrective Action: The cigarette butts were removed by The Maintenance Assistant on 10/9/2025.

Additional Corrective Action: This property is located at public thoroughfares and has shared parking with multiple businesses, with no way to secure the area from passerby and patrons of neighboring businesses. The Executive Director will ensure there are "No Smoking" signs posted on the side of the building and at the rear of the building by 11/14/2025. The smoking area will be identified with a sign as well. Staff were trained by the Executive Director

144c1 Smoking Area Guidelines (continued)

on 10/16/2025 on the smoking policy, the smoking area, and the need to report any debris found to the Maintenance Department for removal.

Ongoing Quality Assurance Actions: The Maintenance Director will complete a daily walk of the exterior property and remove any smoking debris, beginning 10/9/2025. This will be reviewed as part of the quarterly QA meeting to ensure ongoing compliance, beginning January 2026 for review of Q4 2025 (October, November, December).

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

Implemented (- 12/08/2025)

181d -Storing Medication

14. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident is able to self administers medications. The resident lives in a shared bedroom with a resident # who cannot self administer their own medications. On at 4:00 p.m., there were several unlocked, unattended medications to include and in resident s bedroom.

Plan of Correction ***Accept - 11/24/2025)***

Immediate Corrective Action: The Executive Director provided resident # with a lock box on 10/10/2025.

Additional Corrective Action: Resident #4 was educated by the Executive Director that medications needed to be locked in a safe and secure location.

Ongoing Quality Assurance Actions: Utilizing the "medication cart audit form" the Clinical Care Coordinator will audit resident #4 medication to ensure that they are locking them within the lockbox. This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review of Q4 2025 (October, November, December)

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

Implemented - 01/20/2026)

183b - Meds and Syringes Locked

15. 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

At approximately 9:30 a.m., the medication cart located on the 4th floor west wing by the laundry room was unlocked

183b - Meds and Syringes Locked (continued)

and unattended by staff.

Repeat violation: [redacted] *et al.*

Plan of Correction ***Accept*** [redacted] ***- 11/24/2025)***

Immediate Corrective Action: The Business Office Director immediately locked the 4th floor medication cart on 10/8/2025.

Additional Corrective Action: All med techs were educated by the Resident Care Director on 10/16/2025 to lock medications carts at all times.

Ongoing Quality Assurance Actions: The Clinical Care Coordinator will audit at least one med cart per day utilizing the "Medication Cart Audit Form" to ensure medication carts are locked at all times beginning 10/9/2025. This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review of Q4 2025 (October, November, December)

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

Implemented [redacted] ***- 12/08/2025)***

184c - Sample Prescription Meds.

16. Requirements

2600.
184.c. Sample prescription medications shall have written instructions from the prescriber that include the components specified in subsection (a).

Description of Violation

Sample Juven packets belonging to Resident [redacted] *were in the home's medication cart. The written instructions from the prescriber were not attached to the medication.*

Plan of Correction ***Accept*** [redacted] ***- 11/24/2025)***

Immediate Corrective Action: Resident [redacted] *Juven packets were removed from their apartment and physician was notified by the Clinical Care Coordinator that orders needed to be sent to pharmacy on 10/8/2025.*

Additional Corrective Action: The Clinical care coordinator educated all med techs on 10/16/2025 that medications need to be stored in the medication carts with prescription orders unless resident is able to self-administer.

Ongoing Quality Assurance Actions: The Clinical care coordinator and Resident Care Director will audit all medication carts by using the "medication cart audit form" to ensure all medications have prescription orders and that medications are located in resident rooms unless they are self-administration. This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review of Q4 2025 (October, November, and December)

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

Implemented [redacted] ***- 12/08/2025)***

184c - Sample Prescription Meds. *(continued)*

185a - Implement Storage Procedures

17. 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 [redacted] Resident [redacted]s glucometer was calibrated to [redacted]

Resident [redacted] has an order for blood glucose testing 4 times daily in the morning, afternoon, evening and at bedtime. On [redacted] at 9:00 a.m. the resident had a [redacted] reading in the glucometer of [redacted] which was documented on the resident's medication administration record as [redacted]

Repeat violation: [redacted] et al.

Plan of Correction ***Accept[redacted] - 11/24/2025)***

Immediate Corrective Action: On 10/8/2025 The Clinical Care Coordinator recalibrated resident [redacted] glucometer to show correct date.

Additional Corrective Action: All med techs were educated by the Resident Care Director on 10/16/2025 to ensure all glucometers are calibrated and accurate and to ensure that all documentation to the MAR matches the glucometer.

Ongoing Quality Assurance Actions: The Resident Care Director and Clinical Care Coordinator will audit all glucometers weekly to ensure that they match the MAR and are calibrated accurately, this will be audited by using the "Medication Cart Audit Form" beginning on 10/9/2025. This will be reviewed as part of the quarterly QA meetings to ensure ongoing compliance, beginning in January 2026 for review of Q4 2025 (October, November, December)

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

Implemented[redacted] - 01/20/2026)

187a - Medication Record

18. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident [redacted] is prescribed[redacted] tablets to be administered with dinner. However, the resident's October 2025 medication administration record does not indicate the medication should be administered with dinner but instead indicates the medication should be administered in the morning.

187a - Medication Record (continued)

Plan of Correction ***Accept [redacted] - 11/24/2025)***

Immediate Corrective Action: Upon discovery of resident [redacted] bottle not matching the electronic MAR, The Clinical Care Coordinator added a see MAR sticker to the bottle on 10/8/2025. On 10/8/2025 The Clinical Care Coordinator spoke with [redacted] to verify what the correct orders were for resident [redacted]

Additional Corrective Action: The Clinical Care Coordinator educated all med techs on ensuring that the MARS matches the actual medication and orders in the medication carts per our "Medication Management Standards" on 10/16/2025.

Ongoing Quality Assurance Actions: The Clinical Care Coordinator will audit MARs and carts weekly to ensure that medications match documentation/orders in the MAR, by using the medication cart audit form. This will be reviewed as part of the quarterly QA meeting to ensure ongoing compliance, beginning January 2026 for review of Q4 2025 (October, November, December)

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

Implemented [redacted] - 12/08/2025)

187d - Follow Prescriber's Orders

19. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted] tablets to be administered with dinner. However, Resident [redacted] was administered the medication from [redacted] through [redacted] in the morning instead of with dinner.

Resident [redacted] is prescribed [redacted] and [redacted] caplets. However, Resident #[redacted] was not administered the medication on the afternoon of [redacted] as the resident was out of the home without medications.

Resident [redacted] has an order for [redacted] tablets to be administered 3 times daily at 7:00 a.m., 1:00 p.m. and 7:00 p.m. The resident was not administered the medication on [redacted] at 7:00 p.m.

Resident [redacted] has an order for [redacted] tablets to be administered twice daily at 8:00 a.m. and 8:00 p.m. The resident was not administered the medication on [redacted] at 8:00 pm as the resident was out of the home without medication.

Repeat violation: [redacted] et al

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept [redacted] - 11/24/2025)***

Immediate Corrective Action: Upon discovery of resident [redacted] bottle not matching the electronic MAR, The Clinical Care Coordinator added a see MAR sticker to the bottle on 10/8/2025. The Physician and Resident Representative were notified of resident [redacted] not receiving his medications due to being out of the building, DHS reportable was also completed on 10/10/2025.

Additional Corrective Action: The Clinical Care Coordinator educated all med techs on ensuring that the MARS matches the actual medication in the medication carts and that residents need to have their medications per our "Medication Management Standards" on 10/16/2025.

Ongoing Quality Assurance Actions: The Clinical Care Coordinator will audit MARs and carts weekly to ensure that medications match documentation/orders in the MAR, by using the medication cart audit form. This will be reviewed as part of the quarterly QA meeting to ensure ongoing compliance, beginning January 2026 for review of Q4 2025 (October, November, December)

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

Implemented [redacted] - 01/20/2026)

188b - Medication Error Reporting

20. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted] and [redacted] unit caplets. However, Resident [redacted] was not administered the medication on the afternoon of [redacted] as the resident was out of the home without medications. The medication error was not reported to the resident's physician.

Resident [redacted] has an order for [redacted] to be administered 3 times daily at 7:00 a.m., 1:00 p.m. and 7:00 p.m. The resident was not administered [redacted] on [redacted] at 7:00 p.m. The medication error was not reported to the resident's physician.

Resident #[redacted] has an order for [redacted] tablets to be administered twice daily at 8:00 a.m. and 8:00 p.m. The resident was not administered the medication on [redacted] at 8:00 pm as the resident was out of the home without medication. The medication error was not reported to the resident's physician.

Plan of Correction ***Accept [redacted] - 11/24/2025)***

Immediate Corrective Action: The Clinical Care Coordinator notified the resident, physician, and resident representative on 10/8/2025 that resident [redacted] missed his prescribed medications.

188b Medication Error Reporting (continued)

Additional Corrective Action: The Clinical Care Coordinator educated all med techs that they need to notify the resident, physician, and resident representative of any/all missed medications per our "Medication Management Standards" and regulatory requirements. The Resident Care Director will check the dashboard daily and follow up as needed.

Ongoing Quality Assurance Actions: The Clinical Care Coordinator and Resident Care Director will audit daily by using the "medication cart audit form" starting 10/10/2025. This will be reviewed as part of the quarterly QA meeting to ensure ongoing compliance, beginning January 2026 for review of Q4 2025 (October, November, December)

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

Implemented [redacted] - 12/08/2025)

231c - Preadmission Screening

21. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the Secure Dementia Care Unit on [redacted] However, Resident [redacted] written cognitive preadmission screening was not completed by the home.

Plan of Correction ***Accept [redacted] Y - 11/24/2025)***

Immediate Corrective Action: The pre admission screen for resident [redacted] was accurately completed on 10/8/2025 by the Executive Director.

Additional Corrective Action: The Resident Care Director and Clinical Care Coordinator were provided education by the Executive Director on 10/31/2025. The Resident Care Coordinator will audit all current residents to ensure their pre admission screen is complete and accurate.

Ongoing Quality Assurance Actions: Beginning on 11/4/2025 the Resident Care Director will audit 5% sample of resident records by using our "30 day chart audit tool" to ensure that all pre admission screens are completed accurately. This will be reviewed as part of the quarterly QA meeting to ensure ongoing compliance, beginning January 2026 for review of Q4 2025 (October, November, December)

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

Implemented [redacted] 12/08/2025)