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

January 2, 2026

KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC

RE: SPRING MILL SENIOR LIVING
3000 BALFOUR CIRCLE
PHOENIXVILLE, PA, 19460
LICENSE/COC#: 14632

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/09/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SPRING MILL SENIOR LIVING* **License #**: *14632* **License Expiration**: *06/02/2026*

Address: *3000 BALFOUR CIRCLE, PHOENIXVILLE, PA 19460*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *09/10/2009* **Issued By**: *East Pikeland Township*

Type: *I-2* **Date**: *12/02/2016* **Issued By**: *East Pikeland Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *111* **Waking Staff**: *83*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *10/09/2025*

Inspection Dates and Department Representative

10/09/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98* **Residents Served**: *87*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory care* **Capacity**: *22* **Residents Served**: *14*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *87*

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

Have Mobility Need: *24* **Have Physical Disability**: *0*

Inspections / Reviews

10/09/2025 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/20/2025*

12/04/2025 - POC Submission

Submitted By: **Date Submitted**: *12/19/2025*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/19/2025*

Inspections / Reviews *(continued)*

01/02/2026 Document Submission

Submitted By: [redacted]
Date Submitted: *12/19/2025*
Reviewer: [redacted]
Follow Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], at 5:30 AM, resident [redacted] was in resident [redacted]s bedroom screaming "get out of my room" and hitting resident [redacted] with a closed fist on their arm. This incident was observed by staff persons A and B. This incident was reported to staff person C on [redacted] in the evening. However, this allegation of abuse was not reported to the local area agency on aging until [redacted] at 3:00 PM

On [redacted], during the morning shift, resident [redacted] was in in the main lobby sitting on the middle of the couch wearing a disposable depend over [redacted] clothing. Staff person D went over the resident and tore off the depend in view of other residents and staff. This incident was observed by staff person C. However, this allegation of abuse was not reported to the local area agency on aging until [redacted] at 3:40 PM

Plan of Correction ***Accept [redacted] - 12/04/2025)***

- A retraining session on mandated reporting was conducted for the leadership team on September 22, 2025, to reinforce the importance of timely reporting.
- The Executive Director offered in-service training on mandated reporting to the community team on September 30 and October 29, 2025, ensuring that all staff are aware of their reporting responsibilities.
- An additional in-service session on reporting is scheduled for November 25, 2025, to provide further training and support.
- The Executive Director retrained the Memory Care Director and the Director of Health and Wellness to ensure proper follow-up on resident notes by running random reports weekly. This initiative will help identify issues that need to be addressed with primary care providers starting on November 13, 2025.
- The Executive Director initiated monthly audits of incident reports and compliance documentation beginning on October 8, 2025. After the first three months, these audits will transition to a quarterly schedule to ensure ongoing compliance and accountability.
- A behavior tracking form will be developed by November 26, 2025, to alert leadership to issues as they occur. This form will be reviewed during the daily clinical morning meetings, along with all incident reports, to ensure timely awareness and response to any concerns.
- The Executive Director will be responsible for the effective implementation of this plan, which aims to enhance the safety and well-being of residents. All documentation related to audits and training sessions will be maintained to ensure compliance with regulations and facilitate reviews.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent

15a Resident Abuse Report (continued)

remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented (- 01/02/2026)

16c - Written Incident Report

2. 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

On , at 5:30 AM, resident was in resident bedroom screaming "get out of my room" and hitting resident with a closed fist on their arm. This incident was observed by staff persons A and B. And reported to staff person C on in the evening. The home did not report this incident to the department until .

On , during the morning shift, resident was in in the main lobby sitting in the middle of the couch wearing a disposable incontinence brief over clothing. Staff person D went over the resident and tore off the incontinence brief in view of other residents and staff. This incident was observed by staff person C. The home did not report this incident to the department until .

Plan of Correction ***Accept - 12/04/2025)***

A retraining session on mandated reporting was conducted for the leadership team on September 22, 2025, to reinforce the importance of timely reporting in accordance with regulation 2600.16.c.

The Executive Director trained the community team on this regulation on September 30, 2025, ensuring that all staff are aware of their reporting responsibilities regarding abuse incidents.

An additional in service training session for the leadership team and nursing team was offered on November 13, 2025, to further emphasize the importance of compliance with reporting regulations.

The Executive Director conducts frequent trainings where abuse and reporting are key topics, ensuring ongoing awareness among staff.

An additional in service session on reporting is scheduled for November 25, 2025, to provide further training and support for all staff.

The Executive Director initiated monthly audits of incident reports and compliance documentation beginning on October 8, 2025. After the first three months, these audits will transition to a quarterly schedule to ensure ongoing compliance and accountability.

A behavior tracking form will be developed by November 26, 2025, to alert leadership to issues as they occur. This form will be reviewed during the daily clinical morning meetings, along with all incident reports, to ensure timely awareness and response to any concerns.

The Executive Director will be responsible for the effective implementation of this plan, which aims to enhance

16c - Written Incident Report (continued)

the safety and well-being of residents. All documentation related to audits and training sessions will be maintained to ensure compliance with regulations and facilitate reviews.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented (█ - 01/02/2026)

42b - Abuse

3. 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 █, at 5:30 AM, Staff person A reported that they heard yelling coming from a resident bedroom. Staff Person A approached the room and observed resident █ in resident █'s bedroom. Resident █ was screaming "get out of my room" and hitting resident █ with a closed fist on resident █s arm. Resident █'s glasses were askew on █ face from the attack by resident █. Staff Person A intervened and escorted Resident █ out of the room, however, resident █ continued to try to hit and lash out at the staff member. Staff member B overheard the interaction and approached the room as staff member A was escorting resident █ out of the room and observed Resident █ attempting to hit staff member A. Staff member B then escorted resident █ back to their own room, staying outside of resident █ room until they calmed down. For the week following this incident, staff reported that resident █ vividly remembered the incident, telling staff and other residents about it and attempted to barricade themself in their room to feel safe.

Prior to this incident, the resident exhibited other periods of aggression and agitation including an incident on █ when resident █ threw a walker towards other residents in a state of agitation.

Resident █ Resident Assessment dated █, indicates that resident █ required extensive supervision due dementia, confusion and aggression, and indicated that resident █ experiences periods of irritability, especially when other residents enter █ room, or when care staff ask them to do something they do not want to do and that the resident can become both verbally and physically aggressive. As per the residents Support Plan, dated █, staff are to provide regular supervision, encourage resident █ to spend time in common areas, use caution when approaching resident, explain what you planning to do, as well as document problems and report each occurrence. Staff were not checking on resident █ with any defined regularity.

42b Abuse (continued)

Then on ████ resident █ threatened to harm staff and attempted to strike another resident who was sleeping in a wheelchair and on ████ resident █ punched a staff person in their stomach who was attempting to provide care.

The home did not update resident █s assessment and support plan until ████ adding that the resident required half hour checks on all shifts due to agitation and aggression. However, staff were not fully documenting these checks after they were initiated. The home only had documentation of the following days for when the half hour checks occurred:

- *████ from 3:00 PM to 11:00 PM*
- *████ from 3:00 PM to 11:00 PM,*
- *████ and ████ from 3:00 PM to 11:00 PM.*

Plan of Correction ***Accept ██ - 12/04/2025)***

A retraining session on reporting was conducted for the leadership team on September 22, 2025, by the Executive Director, to reinforce the importance of timely reporting in accordance with regulation 2600.16.c.

The Executive Director trained the community team on this regulation on September 30, 2025, ensuring that all staff are aware of their reporting responsibilities regarding abuse incidents.

An additional in service training session by the Executive Director for the leadership team and nursing team was offered on November 13, 2025, to further emphasize the importance of compliance with reporting regulations and following the support plan, including documenting the 30 minute checks.

The Memory Care Director and the Director of Health and Wellness will be jointly responsible for overseeing the implementation and compliance of the half hour check protocol. This includes ensuring that staff are trained and held accountable for their documentation. The Memory Care Director and Director of Health and Wellness were trained by the Executive Director on November 13, 2025.

Compliance will be reviewed with the leadership team during our weekly clinical meeting.

A behavior tracking form will be developed by November 26, 2025, to alert leadership to issues as they occur. This form will be reviewed during the daily clinical morning meetings, along with all incident reports, to ensure timely awareness and response to any concerns.

The Executive Director will conduct sporadic audits of staff documentation for the next three months, after which the audits will transition to random audits effective November 17, 2025. These audits will focus on identifying issues, determining the need for training, and ensuring compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this

42b - Abuse (continued)

plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented - 01/02/2026)

42c - Treatment of Residents

4. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On during the morning shift, resident was in in the main lobby sitting on the middle of the couch wearing a disposable incontinence brief over clothing. Staff person D went over to the resident and without speaking to resident, roughly tore each side of the brief apart and roughly pulled the brief out from under the resident while they remained seated on the couch. There were multiple other residents and staff present in the vicinity who observed this incident.

On at approximately 1:00 PM staff person E witnessed staff person F pushing resident , who was sitting in a wheelchair and who was not wearing pants and only had disposable incontinence brief on bottom half. While staff person pushed the resident into the elevator staff overheard staff person F saying to the resident "Do not touch me" in a harsh tone. Once off the elevator on the second floor, staff person G, who was located in the first-floor lobby at the front desk, reported that they could hear staff person F continuing to speak harshly and yelling at resident as they pushed the wheelchair down the hall. Staff person F was overheard saying "I don't care if you wear pants or not."

Repeat violation:

Plan of Correction ***Accept 12/04/2025)***

- Staff person D and staff person F were terminated to ensure the safety and well-being of residents and team members.
- The Executive Director conducted a training session for the leadership and nursing teams on 11/13/2025. This training focused on the importance of treating residents with dignity and respect and addressed appropriate language and behavior towards residents. The violation was discussed during the training.
- This violation will also be discussed during our community meeting on 11/25/2025. The monthly community meeting will serve as a platform to reinforce the importance of dignity and respect, encouraging open dialogue about resident treatment.
- A behavior tracking form will be developed by November 26, 2025, to alert leadership to issues as they occur. This form will be reviewed during the daily clinical morning meetings, along with all incident reports, to ensure timely awareness and response to any concerns.
- The Executive Director will conduct random interviews with residents and team members on a biweekly basis for the next three months. Following this period, the interviews will transition to a monthly basis for the subsequent six months. This initiative aims to identify issues, listen to concerns, and provide support and coaching.
- The Executive Director will monitor for compliance.

42c Treatment of Residents (continued)

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/27/2025*

Implemented [redacted] - 01/02/2026)

51 - Criminal Background Check

5. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person H's first day of work was [redacted]. A background check was completed [redacted], over a year prior.

Plan of Correction ***Accept [redacted] - 12/04/2025)***

It was determined that the violation occurred because the staff member (Staff Person H) was an agency staff member. A background check was requested on 10/12/2025 to ensure compliance.

The Business Office Director completed an audit on 11/14/2025 to ensure that all background checks for staff in our community were completed and are in compliance with regulatory requirements.

The Business Office Director will conduct audits of staff background checks every six months to ensure ongoing compliance with the background check requirements.

The Executive Director or designee is responsible for signing off on the review of onboarding requirements prior to new staff providing resident care.

The Executive Director will oversee and monitor compliance.

51 - Criminal Background Check (continued)

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/27/2025*

Implemented [redacted] - 12/29/2025)

65a - FS Orientation 1st Day

6. 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 H, whose first day of work was [redacted], 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] 12/04/2025)

- The root cause analysis revealed that staff person H conducted a thorough review of the evacuation procedures, as well as staff duties and responsibilities during fire drills, emergency evacuations, transportation, and at emergency locations. This training was facilitated with a team member who had been trained by a fire safety expert. However, the team member did not sign off on the checklist, resulting in only staff person H's signature being recorded.
- On November 13, 2025, the Executive Director conducted training for the nursing team regarding this regulation, emphasizing the critical importance of documenting the training provided to agency staff. This training aimed to ensure compliance and accountability in our training practices.

65a - FS Orientation 1st Day (continued)

- A checklist for agency staff has been implemented. This checklist will be reviewed and signed by both the agency staff member and the community staff member on their first day of work, ensuring all essential topics are covered.
- The completed orientation checklists for agency staff will be maintained in a dedicated file to ensure compliance and facilitate easy access for audits. This file will be regularly updated and reviewed by the Director of Health and Wellness, the Memory Care Director, and the Assistant Director of Health and Wellness for accuracy.
- The Executive Director will ensure that compliance is consistently monitored and that any issues identified during reviews are addressed promptly.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 01/02/2026)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person I did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques during training year [redacted]

Repeat violation: [redacted] et al

65f - Training Topics *(continued)*

Plan of Correction ***Accept - 12/04/2025)***

- It was determined that the violation occurred because the training platform (Relias) did not assign the required trainings to team members in the activities department.
- The Executive Director offered additional in-service session for the leadership team on November 13, 2025, to further emphasize the importance of adhering to this regulation.
- The Business Office Director has ensured that all required trainings are now assigned to the staff in the activities department. The staff members in this department must complete their assigned trainings by 11/21/2025.
- The Executive Director and the Business Office Director will review compliance of the annual training during daily morning meetings. The department heads will receive a list of staff who need to complete training prior to the training due date. This will ensure compliance and help identify any issues with training assignments.
- The Executive Director will oversee and monitor compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented - 12/29/2025)

65g - Annual Training Content

8. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

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

Repeat violation: et al

65g Annual Training Content *(continued)*

Plan of Correction ***Accept - 12/04/2025)***

The Executive Director offered additional in service session for the leadership team on November 13, 2025, to further emphasize the importance of adhering to this regulation.

The Fire Safety Expert trained staff person I on October 29, 2025.

The root cause determined that the violation occurred because the training platform (Relias) did not assign the required trainings to staff person I in 2024.

The staff person I was trained on Residents Rights on January 11, 2025.

The Business Office Director audited the employee files and confirmed that 95% of team members received in person training from a Fire Safety Person on October 29, 2025. To ensure ongoing compliance, employee files will be audited on each staff member's anniversary date to verify that they receive this training in person. Additionally, files will be audited every six months to maintain accurate training records.

The Executive Director and the Business Office Director will review compliance of the annual training during daily morning meetings. The department heads will receive a list of staff who need to complete training prior to the training due date. This will ensure compliance and help identify any issues with training assignments.

The Executive Director will oversee and monitor compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented 12/29/2025)

95 - Furniture and Equipment

9. Requirements

2600.

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

Description of Violation

On , the keypad located outside of the door to re enter the memory care unit was not properly working because the number 6 key was not functioning.

Plan of Correction ***Accept - 12/04/2025)***

The root cause determined that the door, which is a fire door, has a fire alarm attached to it, but it hasn't been used often due to its fire safety designation.

The keypad was repaired following the findings.

A walkthrough was conducted after the state visit to identify issues and ensure that the equipment in the community was in good repair.

95 - Furniture and Equipment (continued)

- The Director of Facilities will conduct monthly walkthroughs, and documentation of these walkthroughs will be maintained.
- The Executive Director will monitor compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented ██ 01/02/2026)

121a - Unobstructed Egress

10. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On ██, a stop sign was posted next to the door to the pub that exited to the courtyard. This universal image of a stop sign presents an obstruction to the exit in an emergency as it may deter a person from using the exit upon seeing the image.

Plan of Correction ***Accept ██ - 12/04/2025)***

- The root cause determined that the stop sign was improperly placed next to the exit door, creating a potential obstacle during an emergency.
- The stop sign was removed immediately after the state visit to ensure that the exit remained clear and unobstructed.
- A walkthrough was conducted after the removal of the sign to ensure the exit is clear and compliant with safety regulations.
- The Executive Director offered additional in-service session for the leadership team on November 13, 2025, to further emphasize the importance of adhering to this regulation.
- The Director of Facilities will conduct monthly walkthroughs, and documentation of these walkthroughs will be maintained.
- The Executive Director will monitor compliance.

121a - Unobstructed Egress (continued)

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented ███ - 01/02/2026)

182b - Prescription Medication

11. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician’s assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On ████ at 8:10 AM, ████ at 8:17 AM and ████ at 8:18 AM, staff person F administered medications to residents to include the following: ████████ and ████ tablet to resident █.

Staff person F is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

The home could not provide proof of the staff person's initial online trainings, and the staff person had not completed a complete annual practicum within 1 year of their initial certification.

Repeat violation: ████ et al

182b Prescription Medication *(continued)*

Plan of Correction ***Accept (- 12/04/2025)***

The root cause determined that staff person F was hired with a medication certification from previous employment.

Staff person F is no longer employed with the company.

The Executive Director offered additional in service session for the leadership team on November 13, 2025, to further emphasize the importance of adhering to this regulation.

The Medication Administration Trainer conducted a thorough review of all medication administration logs on November 12, 2025, to identify any potential violations and to confirm that they are up to date. Additionally, the Medication Administration Trainer will perform random audits to ensure. Random audits will involve selecting a sample of medication administration logs and staff performance on a monthly basis to verify adherence to protocols. Corrective actions for any findings may include additional training for staff or disciplinary action if necessary. A follow up review is scheduled for February 2026.

The Business Office Director and the Medication Administration Trainer established a process for monitoring compliance by developing and maintaining a centralized database to track training completion for staff, including annual training and medication administration training.

The Business Office Director and the Medication Administrator Trainer will collaborate to send monthly reports to identify any staff who are non compliant.

The Executive Director and the Medication Administration Trainer will verify the validity of medication administration certifications for all new hires by organization's standards by ensuring that any certifications obtained are in alignment with the training requirements.

A mandatory medication administration training is scheduled for all current staff involved in administering medications, regardless of prior certifications, on December 13, 2025.

The Executive Director will monitor for compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *12/13/2025*

Implemented - 12/29/2025)

185a - Implement Storage Procedures

12. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

On [redacted] at 9:06 AM, resident [redacted] [redacted], was documented as administered on the resident's Medication Administration Record (MAR), however the time it was signed out not indicated on the Controlled Substance Medication Record.

On [redacted] at 4:00 AM, resident [redacted] [redacted] tablet, take 1 tablet by mouth every 4 hours was signed out on the
Controlled Substance Medication Record but not documented as administered on the resident's 9/2025 MAR.

The home's controlled substance policy indicates the following:

- *a. All administrations of a Controlled Substance, whether scheduled or PRN, is documented on the MAR.*
- *b. When Controlled Substances are removed from the original packaging (bubble pack, vial, etc.), it is documented on the Controlled Substance Medication Record including: i. Date. ii. Time. iii. Quantity used. iv. Quantity remaining. v. Staff initials."*

Repeat violation: [redacted] et al

Plan of Correction ***Accept ([redacted] - 12/04/2025)***

- A training session conducted by the Executive Director and the Director of Health and Wellness on 10/10/2025 for all staff responsible for medication administration.
- A meeting was held on 11/13/2025 to discuss the violations and regulatory requirements with medication administrators and the leadership team.
- A comprehensive medication training for all nurses and med techs, regardless of certification status, scheduled for 12/13/2025 with a designated med trainer.
- The Director of Health and Wellness and the Health Care Coordinators will conduct Medication Administration Record audits twice a week for the next 4 weeks. After 4 weeks, the audits will transition to once a week for the next 3 months to ensure compliance and identify any ongoing issues. These audits will also include a med tech-to-med tech shift count of controlled substances.
- The Director of Health and Wellness will conduct regular check-ins with the staff to address any challenges and provide additional support or training as needed.
- The Executive Director will monitor the implementation of this plan for compliance, reviewing audit results and staff feedback regularly.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

185a - Implement Storage Procedures *(continued)*

Implemented (- 01/02/2026)

187b - Date/Time of Medication Admin.

13. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident is prescribed take 1 tablet by mouth every 4 hours for pain. Resident medication administration record does not include the initials of the staff person who administered this medication on at 4:00 AM.

This medication was signed out of the resident's controlled substance log at at 4:00 AM.

Repeat violation: et al

Plan of Correction ***Accept - 12/04/2025)***

- A training session conducted by the Executive Director and the Director of Health and Wellness on 10/10/2025 for all staff responsible for medication administration.
- A meeting was held on 11/13/2025 to discuss the violations and regulatory requirements with medication administrators.
- A comprehensive medication training for all nurses and med techs, regardless of certification status, scheduled for 12/13/2025 with a designated med trainer.
- The Director of Health and Wellness and the Health Care Coordinators will conduct Medication Administration Record audits twice a week for the next 4 weeks. After 4 weeks, the audits will transition to once a week for the next 3 months to ensure compliance and identify any ongoing issues. These audits will also include a med tech-to-med tech shift count of controlled substances.
- The Director of Health and Wellness will conduct regular check-ins with the staff to address any challenges and provide additional support or training as needed.
- The Executive Director will monitor the implementation of this plan for compliance, reviewing audit results and staff feedback regularly.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

187b Date/Time of Medication Admin. *(continued)*

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented (█ - 01/02/2026)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident █ is prescribed █ tablet and █ tablet to be taken at 9:00 AM. However, resident █ was administered these medications on █ at 10:11 AM.

Resident █ is prescribed █ take 1 tablet by mouth every 4 hours for pain. However, this medication was not administered to resident █ on █ at 8:00 PM and █ at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM because the medication was not available in the home.

Repeat violation: █ et al

Plan of Correction ***Accept (█ - 12/04/2025)***

A training session conducted by the Executive Director and the Director of Health and Wellness on 10/10/2025 for all staff responsible for medication administration.
A meeting was held on 11/13/2025 to discuss the violations and regulatory requirements with medication administrators and the leadership team.
A comprehensive medication training for all nurses and med techs, regardless of certification status, scheduled for 12/13/2025 with a designated med trainer.
The Director of Health and Wellness and the Health Care Coordinators will conduct Medication Administration Record audits twice a week for the next 4 weeks. After 4 weeks, the audits will transition to once a week for the next 3 months to ensure compliance and identify any ongoing issues. These audits will also include a med tech to med tech shift count of controlled substances.
The Director of Health and Wellness will conduct regular check ins with the staff to address any challenges and provide additional support or training as needed.
A Medication Availability Checklist has been developed to be completed weekly by nursing staff to ensure that all prescribed medications are on hand. This checklist will be implemented on November 20, 2025, following the training scheduled with the Director of Health and Wellness, health care coordinators, and med techs. The training will be provided by the Executive Director.
The Executive Director will monitor the implementation of this plan for compliance, reviewing audit results and staff feedback regularly.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state

187d Follow Prescriber's Orders (continued)

rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented - 01/02/2026)

201 - Positive Interventions

15. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

On , at 5:30 AM, resident was in resident bedroom screaming "get out of my room" and hitting resident with a closed fist on their arm. Resident 's glasses were askew from face. For the week following the incident staff interviewed reported that resident vividly remembered the incident, telling staff and other residents about it and attempted to barricade in room.

On resident threatened to harm staff and attempted to strike another resident.

The home did not update resident assessment and support plan until adding that the resident required half hour checks due to agitation and aggression. The home only provided documentation of the following days half hour checks occurred, from 3:00 PM to 11:00 PM, from 3:00 PM to 11:00 PM, , and from 3:00 PM to 11:00 PM.

The home has not implemented positive interventions to modify or eliminate the behavior.

Plan of Correction ***Accept 12/04/2025)***

A meeting was held on 11/13/2025 to discuss the violations and regulatory requirements with the nursing team and the leadership team.

Resident 1's assessment and support plan was updated on November 17, 2025, to include specific positive interventions tailored to address aggressive behaviors.

A 1:1 staff member was assigned effective November 16, 2025, to ensure that resident 1 does not enter other residents' rooms.

A mandatory training session for staff on positive behavior interventions and conflict resolution techniques will be conducted by Caring Home Care and Grane Hospice on November 25, 2025. Training topics will include effective communication, redirection strategies, de escalation techniques, and methods for identifying and defusing potential emergency situations.

The Executive Director will conduct random interviews with residents and team members on a biweekly basis for the next three months. Following this period, the interviews will transition to a monthly basis for the subsequent six months. This initiative aims to identify issues, listen to concerns, and provide support and coaching effective November 24, 2025.

The Executive Director trained the Memory Care Director and the Director of Health and Wellness on the

201 Positive Interventions (continued)

importance of regularly reviewing support plans to ensure that positive interventions are included for residents with challenging behaviors on November 13, 2025.

A behavior tracking form will be developed and reviewed daily during the clinical morning meetings. This review will include updates to the support plans based on the tracked behaviors and interventions. Additionally, a 24 hour behavior log will be maintained and reviewed daily to capture any incidents or relevant observations that occur between meetings.

The Executive Director will monitor for compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 01/02/2026)

225c - Additional Assessment

16. 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

On [redacted] resident [redacted] attacked resident [redacted] The Home did not update resident [redacted] assessment until [redacted] to indicate resident [redacted]s need for additional supervision.

Resident [redacted]s most recent assessment was completed on [redacted]

Repeat violation: [redacted] et al

Plan of Correction ***Accept ([redacted] - 12/04/2025)***

A meeting was held on 11/13/2025 to discuss the violations and regulatory requirements with the nursing team and the leadership team.

Resident 1's assessment and support plan was updated on November 17, 2025, to include specific positive interventions tailored to address aggressive behaviors and 1:1 staff supervision.

The Executive Director provided training to the Memory Care Director and the Director of Health and Wellness on

225c - Additional Assessment (continued)

November 13, 2025, on the critical importance of routinely reviewing support plans to ensure that they accurately reflect the evolving needs of residents.
- A process will be established to monitor and track condition changes that require updates to resident assessments and support plans. This will include regular assessments by nursing staff, a standardized form for documenting changes in behavior or health status, and a protocol for reporting significant changes to the Director of Health and Wellness.
- Regular review meetings will also be held to evaluate these documented changes and determine necessary updates to support plans.
- The Executive Director will monitor for compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 01/02/2026)

227g -Support Plan Signatures

17. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident [redacted] participated in the development of [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

Plan of Correction ***Accept ([redacted] - 12/04/2025)***

- The root caused determined that the resident was unable to sign the support plan.
- On November 13, 2025, the Executive Director conducted training for the Memory Care Director and the Director of Health and Wellness focused on the importance of checking the box indicating "unable to sign" when a resident is not able to provide their signature.
- A comprehensive audit of all Resident Assessment Support Plans i our memory care unit was conducted to ensure compliance with the signature requirements. This audit confirmed that all support plans accurately reflect the participation and signing status of residents.
- The Memory Care Director and the Director of Health and Wellness will be responsible for conducting routine audits of support plans to ensure ongoing compliance with this regulation. Audits will be scheduled quarterly to

227g -Support Plan Signatures (continued)

verify that all necessary signatures are obtained and that cases of residents unable to sign are appropriately documented
- The Executive Director will review the auditing process and findings on a quarterly basis to ensure compliance and address any further issues that may arise.

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Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented (- 01/02/2026)

234a - Admission Support Plan

18. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident’s admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident was admitted to the Secure Dementia Care Unit (SDCU) on However, the resident’s initial support plan was completed on .

Plan of Correction ***Accept - 12/04/2025)***

- The root cause determined that the delay in completing the support plan was identified as a procedural oversight in documenting the support plan within the required timeframe.
- On November 13, 2025, the Executive Director conducted training for the Memory Care Director and the Director of Health and Wellness on the importance of developing, implementing, and documenting the support plan within 72 hours of admission to the Secure Dementia Care Unit. This training emphasized adherence to regulatory requirements and the impact on resident care.
- The Memory Care Director and Director of Health and Wellness will be responsible for conducting routine audits of admission support plans. These audits will occur monthly for the next six months to ensure compliance with the regulatory requirements.
- During the morning clinical meeting, we will review new admission documentation and assessment requirements to ensure timeliness and compliance. This review will help us identify any potential delays and implement necessary improvements to streamline the admission process.
- The Executive Director will review the auditing process and findings on a quarterly basis to ensure compliance and address any further issues that may arise.

234a Admission Support Plan (continued)

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented ██ - 01/02/2026)

252 - Record Content

19. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).

252 Record Content *(continued)*

25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

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

Repeat violation: [redacted] et al

Plan of Correction ***Accept ([redacted] - 12/04/2025)***

The root cause was identified as a procedural oversight in the documentation process regarding the inclusion of current photographs in resident records.

On November 13, 2025, the Executive Director conducted training for the Memory Care Director and the Director of Health and Wellness on the importance of maintaining accurate and up to date resident records, including the requirement for photographs taken within the last two years. This training emphasized adherence to regulatory standards and the significance of accurate documentation in resident care.

The Memory Care Director and Director of Health and Wellness will be responsible for conducting routine audits of resident records monthly for the next six months. These audits will specifically check for the inclusion of current photographs and compliance with documentation requirements.

During the morning clinical meeting, we will review new admission documentation and assessment requirements to ensure timeliness and compliance. This review will help us identify any potential delays and implement necessary improvements to streamline the admission process.

The Executive Director will review the auditing process and findings on a quarterly basis to ensure ongoing compliance and to address any further issues that may arise regarding resident documentation.

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Licensee's Proposed Overall Completion Date: *11/26/2025*

Implemented [redacted] - 01/02/2026)