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

January 13, 2026

[redacted]
SNH PENN TENANT LLC
[redacted]
TWO NEWTON PLACE
[redacted]

RE: OVERLOOK GREEN
5250 MEADOWGREEN DRIVE
PITTSBURGH, PA, 15236
LICENSE/COC#: 45057

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/16/2025 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: *OVERLOOK GREEN* **License #**: *45057* **License Expiration**: *07/01/2026*

Address: *5250 MEADOWGREEN DRIVE, PITTSBURGH, PA 15236*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *SNH PENN TENANT LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *84* **Waking Staff**: *63*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *10/16/2025*

Inspection Dates and Department Representative

10/16/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *128* **Residents Served**: *71*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *D Wing* **Capacity**: *23* **Residents Served**: *8*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *70*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *13* **Have Physical Disability**: *1*

Inspections / Reviews

10/16/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/09/2025*

11/12/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/08/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/19/2025*

Inspections / Reviews *(continued)*

11/25/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/24/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *12/15/2025*

01/13/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/15/2025*

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

65a - FS Orientation 1st Day

1. 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:
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.

Description of Violation

Direct care staff person A, hired on [redacted], did not receive orientation on the following topics:

- *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*
- *The location and use of fire extinguishers*
- *Smoke detectors and fire alarms*

Plan of Correction ***Directed [redacted] - 11/25/2025)***

- On 11/5/25 Staff person A was provided with and completed a full fire safety and emergency preparedness orientation. Training documentation, including a signed orientation checklist covering all required topics, has been placed in the employee's personnel file.
- The Administrator/Designee reviewed and revised the New Employee Orientation Checklist to ensure all fire safety and emergency preparedness topics listed under regulation 2600.65(a) are clearly included and checked off during the first workday.
- Effective immediately, no staff person will be permitted to begin unsupervised work duties until the full orientation —including the four required fire safety elements—is completed and documented.
- Administrator or Designee is responsible for ensuring all new staff receive and document required first-day fire safety orientation.
- Administrator/designee will review all current staff records to ensure all staff orientation training has been completed and checked off by 11/30/25
- The Administrator or designee will audit all new employee files within 5 business days of hire to verify completion of all required first-day fire safety orientation topics beginning 11/4/2025.
- Beginning 11/15/25 the Administrator or designee will conduct a quarterly random review of 3 staff files to ensure continued compliance with regulation 2600.65(a)
- The next Quality Management Review meeting will occur 12/10/25 and will include a review of all items specified in 2600.26b (DIRECTED: Documentation of the quality management review shall be kept. [redacted] 11/25/25).

Proposed Overall Completion Date: 12/10/2025

Directed Completion Date: *12/10/2025*

Implemented [redacted] - 01/13/2026)

65b - Rights/Abuse 40 Hours

2. Requirements

65b Rights/Abuse 40 Hours *(continued)*

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Direct care staff person A, hired on [redacted] did not receive training on the following topics:

- *Emergency medical plan*
- *Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act*
- *Reporting of reportable incidents and conditions*

Plan of Correction ***Accept [redacted] - 11/25/2025)***

- On 11/5/25 staff person A completed orientation and training on all required topics listed above. Training materials and a signed acknowledgment form have been placed in the employee's personnel file.

- The Administrator/Designee has updated the New Employee Orientation Schedule and Checklist to clearly indicate that the emergency medical plan, mandatory reporting of abuse/neglect, and reporting of incidents must be completed within the first 40 scheduled working hours.

- The orientation checklist will be signed and dated by both the new employee and the trainer upon completion of each required topic.

- A tracking log was implemented on 11/4/25 to monitor completion of all required training elements and timeframes for each new hire.

- Administrator reviewed records on 11/4/25 to ensure all current staff have received training on all topics specified in regulation 2600.65b

- Administrator or Designee is responsible for ensuring all staff complete the required 40-hour orientation topics within the specified timeframe immediately with new hires beginning 11/10/15

- The Administrator or designee will review all new employee orientation files within five business days after the first 40 scheduled working hours to verify completion of required training.

- The Administrator or designee will audit all new employee files within 5 business days of hire to verify completion of all required new employee orientation topics are covered beginning 11/4/2025.

- Beginning 11/15/25, administrator or designee will conduct a quarterly audit of staff files to ensure continued compliance with regulation 65(b).

- Any deficiencies identified will be corrected immediately, and retraining will be conducted as needed.

Licensee's Proposed Overall Completion Date: *11/24/2025*

Implemented [redacted] - 01/13/2026)

65g Annual Training Content

3. 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.

65g - Annual Training Content *(continued)*

Description of Violation

Direct care staff person B, hired on [redacted], did not receive training on the following topics during the 2024 training year:

- *Fire safety completed by a fire safety expert or by a staff trained by a fire safety expert*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations*

Direct care staff person C, hired on [redacted], did not receive training on the following topics during the 2024 training year:

- *Fire safety completed by a fire safety expert or by a staff trained by a fire safety expert*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations*

REPEAT VIOLATION: [redacted] et. al.

Plan of Correction ***Directed [redacted] - 11/25/2025)***

- On 11/5/25 staff persons B and C completed the required annual fire safety training conducted by a qualified fire safety expert, as well as emergency preparedness and crisis response training.
- Documentation of both trainings, including attendance sheets, training materials, and trainer credentials, has been filed in each employee's personnel record.
- On 11/4/25, the Administrator/Designee reviewed and updated the facility's Annual Training Calendar to ensure all required annual trainings under regulation 2600.65g are clearly scheduled, documented, and tracked on an ongoing basis
- On 11/4/25 a Training Log was developed to record the completion date, trainer's name/credentials, and training topics for each staff member.
- The facility will ensure that all annual fire safety training is conducted by a fire safety expert or a staff person trained by one, and that emergency preparedness/crisis response training is completed concurrently.
- The Administrator or Designee is responsible for scheduling, tracking, and documenting annual staff training in compliance with regulation 2600.65(g) and will conduct any missing trainings current staff members may have by 11/30/25
- Beginning 11/15/25, Administrator or designee will conduct quarterly reviews of the Training Log to ensure all required annual trainings are completed within the training year.
- An automated reminder system (calendar alerts) will be used to notify management of upcoming training due dates at least 60 days in advance.
- Any missed or overdue training will be addressed immediately, with retraining documented within 5 business days of identification.
- The results of quarterly training audits will be reviewed during Quality Management meetings to ensure continued compliance with regulation 2600.65(g).

Proposed Overall Completion Date: 11/24/2025

Directed Completion Date: *11/30/2025*

Implemented ([redacted] - 01/13/2026)

65i - Training Record

4. Requirements

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

Description of Violation

Direct care staff persons B and C's 2024 annual training records do not include the length of each course, to include the following trainings:

- *Direct care staff person B's infection control training, conducted on* [redacted]
- *Direct care staff person B's Alzheimer's training, conducted on* [redacted]
- *Direct care staff person C's incident reporting training, conducted on* [redacted]
- *Direct care staff person C's abuse reporting training, conducted on* [redacted]

Plan of Correction ***Accept*** [redacted] ***11/25/2025)***

- The Administrator reviewed the training documentation for staff persons B and C with the Director of Health and Wellness. The course lengths for each of the identified trainings were verified with the training source and have now been added to the training records, re-education was not needed as this was a clerical oversight.
- Beginning 11/25/25, within 5 days upon completion of a course, Administrator or designee will review training record to ensure accuracy.
- Updated training records now include: staff person name, date, source, content, length of training, and copies of any certificates received on 11/5/25
- The Administrator (or designee) reviewed regulation 2600.65(i) and updated the facility's Training Record Form to include a required field for "Length of Training."
- Going forward, all training records will be reviewed immediately after each training to ensure that all required components—including course length—are documented before being filed.
- The Administrator will conduct quarterly audits of staff training files to verify completeness and compliance with regulation 2600.65(i) and will ensure all 2025 training files are accurate and training complete by 12/31/25
- Results of the quarterly audits will be reviewed during Quality Management meetings, and any deficiencies will be corrected immediately.
- The next Quality Management Review meeting will occur 12/10/25 and will include a review of all items specified in 2600.26b

Licensee's Proposed Overall Completion Date: *12/10/2025*

Implemented ([redacted] ***- 12/16/2025)***

82c - Locking Poisonous Materials

5. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At 10:05am, the following poisonous materials, which contained a manufacturers' labels indicating to call a poison control center or doctor for treatment advice if ingested, were unlocked, unattended and accessible to residents in the C wing housekeeping closet:

- *4 bottles of Emerel Multi-Surface Creme Cleanser*
- *2 bottles of Virex Tb Disinfectant Cleanser*

82c - Locking Poisonous Materials (continued)

- *2 bottles of Husky Creme Cleanser*

Not all the residents of the home, including resident [redacted], have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Directed [redacted] 11/25/2025)***

- Immediately upon discovery, all poisonous materials located in the C Wing housekeeping closet were secured in a locked cabinet, inaccessible to residents.
- The housekeeping closet door was fitted with a coded door lock on 10/17/2025, and all staff were instructed to ensure it remains locked when unattended and only designated staff members were provided with the door code.
- An audit was conducted by the Director of Facilities of all other housekeeping and storage areas and coded door locks were installed on each of their entries to ensure all poisonous materials are properly secured on 10/17/25.
- All staff were re-trained on regulation 2600.82(c) regarding the proper storage of poisonous materials and the requirement that such materials remain locked and inaccessible to residents on 11/5/25. Training included review of what constitutes a "poisonous material" under manufacturer labeling.
- The Director of Facilities or designee will conduct weekly random audits of a walkaround of the entire home until 12/30/25 to ensure compliance and then monthly thereafter (DIRECTED: The weekly audits shall begin on 12/1/25. [redacted] 11/25/25).
- Results of weekly and monthly safety audits will be reviewed during staff meetings. Any identified issues will be corrected immediately, and additional staff coaching will be provided as needed.

Documentation uploaded

Proposed Overall Completion Date: 12/30/2025

Directed Completion Date: *12/01/2025*

Implemented [redacted] - 01/13/2026)

183b - Meds and Syringes Locked

6. 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 10:12am, there was a treatment cart unlocked, unattended and accessible in the wellness office, which included medications for numerous residents, to include the following:

- [redacted]
- [redacted]
- [redacted]

Plan of Correction ***Directed [redacted] - 11/25/2025)***

- Immediately upon discovery, the treatment cart in the wellness office was locked and secured.
- On 10/17/25 Director of Health and Wellness conducted a full audit of all medication storage areas and carts

183b Meds and Syringes Locked (continued)

was conducted to verify that all medications and syringes are properly stored in locked and secured containers.

Staff were reminded that treatment carts must remain locked at all times when not in use and may never be left unattended while open.

On 10/17/25, Director of Health and Wellness conducted a training for all nurses and Medication Technicians on regulation 2600.183(b), emphasizing: Medications and syringes must remain locked when not in direct use, treatment carts must remain in staff possession and attended if unlocked and the procedure to secure carts prior to leaving any area. (DIRECTED: Documentation of staff education will be kept in accordance with 2600.65i. [redacted] 11/25/25).

The Director of Health and Wellness or Designee will conduct daily medication area checks ending on 12/30/25, and weekly thereafter, to ensure full compliance on an ongoing basis: (DIRECTED: The daily audits shall begin on 12/1/25.[redacted] 11/25/25).

Audit results will be reviewed in staff meetings, and any deficiencies will result in immediate retraining.

Beginning 11/15/25, continued compliance will be monitored through unannounced spot monthly checks of medication carts and nurse stations during all medication administration shifts by the Director of Health and Wellness or Designee.

Documentation uploaded

Proposed Overall Completion Date: 11/24/2025

Directed Completion Date: *12/01/2025*

Implemented [redacted] - 12/16/2025)

186a - Authorized Prescriber

7. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

At the time of inspection, resident [redacted] had a blister pack of [redacted] tablets Take 1 tablet by mouth 1 time a day present in the home; however, resident [redacted] October 2025 MAR indicates [redacted] tablets Take 1 tablet by mouth 1 time a day. No current prescription order for this medication was present for resident [redacted], so it is unable to be determined which is correct.

Plan of Correction ***Directed ([redacted] - 11/25/2025)***

• The medication for resident [redacted] was immediately set aside and not administered until clarification was received from the prescriber.

• The resident's physician was contacted on the day of the inspection 10/15/25 to verify the correct dosage and issue a current, written prescription order which was received and placed in resident's file on 10/16/25.

• On 10/16/25 Director of Health and Wellness updated MAR to reflect the verified prescription, and any outdated or incorrect medications were removed from the medication storage area and properly disposed of in accordance with facility policy

• Medication administration staff were retrained by Director of Health and Wellness on 10/16/25 and 10/17/25 on regulation 2600.186(a) requirements, with emphasis on verifying that: each medication has a current written prescriber order on file and any discrepancy between the MAR, prescription, or medication packaging is

186a - Authorized Prescriber (continued)

immediately reported to the Director of Health and Wellness for clarification before administration (DIRECTED: Documentation of staff education will be kept in accordance with 2600.65i. [redacted] 11/25/25).
- Beginning 10/16/25 Director of Health and Wellness or designee will obtain any new orders and update the MAR immediately upon receipt
Documentation uploaded

DIRECTED: Beginning on 12/1/25: The Director of Wellness/designee shall review at least 3 different resident records weekly to ensure copies of all current physician orders are present in each resident's record.[redacted] 11/25/25

Proposed Overall Completion Date: 11/24/2025

Directed Completion Date: *12/01/2025*

Implemented [redacted] - 01/13/2026)

187a - Medication Record

8. Requirements

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

Description of Violation

Resident #[redacted] is currently prescribed [redacted] tablet-Take 1 tablet by mouth every 12 hours as needed; however, resident [redacted]s October 2025 medication administration record (MAR) indicates [redacted] tablet-Take 1 tablet by mouth 2 times a day.

Plan of Correction ***Directed [redacted] - 11/25/2025)***

- The medication order for resident [redacted] was reviewed with the prescriber to verify the correct administration frequency ("every 12 hours as needed").
- The resident's MAR was immediately corrected by Director of Health and Wellness to match the current prescription order on 10/15/25.
- Medication administration staff were informed of the correction and reminded to administer the medication only as prescribed on 10/16/25 and 10/17/25 by the Director of Health and Wellness
- All MARs were reviewed for accuracy to ensure that the frequency of administration on each record matches the corresponding prescriber's order by the Director of Health and Wellness on 10/16/25 and 10/17/25.
- All medication administration staff were retrained by Director of Health and Wellness on 10/16/25 and 10/17/25 on regulation 2600.187(a), with emphasis on verifying that the MAR accurately reflects the prescriber's written order, especially regarding PRN ("as needed") versus scheduled doses. (DIRECTED: Documentation of staff education will be kept in accordance with 2600.65i. [redacted] 11/25/25).
- Beginning 11/1/25, the Director of Health and Wellness or designee will perform monthly medication record audits to ensure that all MARs accurately reflect current prescriber orders. (DIRECTED: At least 15 different residents shall be included in each monthly audit. [redacted] 11/25/25).
- Any discrepancies will be corrected immediately and reviewed with the responsible staff member for retraining if needed.
Documentation uploaded

187a - Medication Record (continued)

Proposed Overall Completion Date: 11/24/2025

Directed Completion Date: *11/25/2025*

Implemented (- 01/13/2026)

187b - Date/Time of Medication Admin.

9. 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 currently prescribed tablet-Give 1 tablet by mouth 1 time a day for . This medication has not administered to resident since around because the medication has not been available in the home for administration; however, resident October 2025 MAR indicates the medication was administered to resident on and .

REPEAT VIOLATION:

Plan of Correction ***Directed (- 11/25/2025)***

- The MAR was reviewed by the Director of Health and Wellness on 10/16/25, and incorrect entries have been corrected.
- The root cause of the issue and reason medication was not available was family did not supply refill on time and did not respond to many attempts Director of Health and Wellness made to bring refill in a timely manner.
- Resident #9's physician was notified on 10/16/26 by Director of Health and Wellness of missed doses and appropriate follow-up orders were obtained.
- Cyanocobalamin was obtained from the family on 10/17/25.
- Staff involved in documentation of medication administration were re-educated by the Director of Health and Wellness on 10/16/25 and 10/17/25 regarding accurate MAR documentation and the requirement to record administration at the time the medication is given, including protocols for documenting missed doses. (DIRECTED: Documentation of staff education will be kept in accordance with 2600.65i. 11/25/25).

DIRECTED: Beginning on 12/1/25: The Director of Wellness/designee shall review at least 15 different resident MAR's per month to ensure accuracy and completeness in accordance with 2600.187b. 11/25/25).

Proposed Overall Completion Date: 11/24/2025

Directed Completion Date: *12/01/2025*

Implemented - 01/13/2026)

187d - Follow Prescriber's Orders

10. Requirements

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

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

Description of Violation

Resident [redacted] is currently prescribed [redacted] tablet Give 1 tablet by mouth 1 time a day for [redacted] however, this medication has not administered to resident [redacted] since around[redacted], because the medication has not been available in the home for administration.

Plan of Correction ***Directed ([redacted] - 11/25/2025)***

Resident #9's physician was immediately notified of missed doses, and follow up orders were obtained.

Cyanocobalamin medication was obtained from the family and available on 10/17/25

The medication was not present because the family did not supply refill on time and did not respond to many attempts Director of Health and Wellness made to bring refill in a timely manner.

Beginning 10/16/25 Director of Health and Wellness or designee will verify daily that all MARs are updated and orders have been entered.

Staff were re educated by the Director of Health and Wellness on 10/16/25 and 10/17/25 regarding the importance of following prescriber orders without delay and documenting any missed doses promptly. (DIRECTED: Documentation of staff education will be kept in accordance with 2600.65i. [redacted] 11/25/25).

DIRECTED: Beginning on 12/1/25: The Director of Wellness/designee shall review all medications and MAR's for at least 15 different residents monthly to ensure accurate and complete medication administration documentation is present and that all prescribed medications are present in the home and available for administration in accordance with prescribers' orders. [redacted] 11/25/25

Proposed Overall Completion Date: 11/24/2025

Directed Completion Date: *12/01/2025*

Implemented [redacted] - 01/13/2026)

227d - Support Plan Medical/Dental

11. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident [redacted] is currently receiving hospice services; however, resident [redacted] most recent support plan, dated [redacted], does not include the specific services or frequency of services resident [redacted] is receiving from hospice.

Plan of Correction ***Directed [redacted] - 11/25/2025)***

Director of Health and Wellness updates Resident [redacted] support plan on 10/15/25 to include hospice services being provided and frequency of these services

Hospice provider was contacted by Director of Health and Wellness on 10/15/25 to verify all current services and schedule, ensuring accurate documentation.

Staff responsible for support plan updates were re educated by Director of Health and Wellness on the requirement to document all medical and behavioral care services in the support plan by the Director of Health and Wellness on 10/16/25 and 10/17/25. (DIRECTED: Documentation of staff education will be kept in accordance with 2600.65i. [redacted] 11/25/25).

227d - Support Plan Medical/Dental (continued)

- Beginning 11/1/25 all residents' support plans will be reviewed monthly by Director of Health and Wellness or Designee to ensure that any medical, dental, vision, hearing, mental health, behavioral, or hospice services are accurately documented, including frequency and provider information
- Beginning 11/1/25 Director of Health and Wellness or designee will audit support plans quarterly to ensure compliance.
- Any missing information will be immediately corrected, and staff will be counseled as needed.
Documentation uploaded

Proposed Overall Completion Date: 11/24/2025

Directed Completion Date: *11/25/2025*

Implemented [redacted] - 01/13/2026)

254c - Records Storing

12. Requirements

2600.
254.c. Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

Description of Violation

At 10:12am, approximately 21 resident records, including the records for resident [redacted] and [redacted], were unlocked, unattended and accessible in the wellness office, which contained the residents' assessments, medical evaluations, physician orders and nursing notes.

Plan of Correction ***Directed ([redacted] - 11/25/2025)***

- All resident records were immediately secured in a locked cabinet and the door handle to enter the room was replaced with a coded lock on 10/17/25 in which code was only shared with the appropriate designated staff members.
- Staff present were reminded of the requirement to lock and secure resident records at all times when unattended.
- The administrator conducted a review of the wellness office to ensure all areas where resident records are kept are compliant with regulation 2600.254(c) on 10/17/25.
- Mandatory in-service trainings for all staff on proper handling, storage, and confidentiality of resident records with be conducted by 12/15/25. (DIRECTED: Documentation of staff education will be kept in accordance with 2600.65i. [redacted] 11/25/25).
- Director of Health and Wellness or Designee will perform daily checks of both wellness offices for one month to ensure all records are stored securely ending on 12/15/25, (DIRECTED: The daily audits shall begin on 12/1/25.[redacted] 11/25/25). Monthly audits will be conducted thereafter to maintain compliance.

Proposed Overall Completion Date: 12/15/2025

Directed Completion Date: *12/15/2025*

Implemented [redacted] 01/13/2026)