pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **CARE HSL NEWTOWN OPCO LLC**
LEGAL ENTITY

To operate **THE BIRCHES AT NEWTOWN**
NAME OF FACILITY OR AGENCY

Located at **70 DURHAM ROAD, NEWTOWN, PA 18940**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **120**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

PROVISIONAL

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 57**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **March 25, 2026** until **September 25, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **142301**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 25, 2026

[redacted]
President, COO
Care HSL Newtown OPCO LLC
% Heritage Senior Living
[redacted]

RE: The Birches at Newtown
70 Durham Road
Newtown, Pennsylvania 18940
License #: 142301

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection October 22 and 24, 2025 and January 8, 2026 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 142300 dated September 15, 2025 to September 15, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from MARCH 25, 2026 to SEPTEMBER 25, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

Mr. Matthew Hayden

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
51	III	105	$3	$315	15 calendar days from mailing date of this letter
54a	III	105	$3	$315	15 calendar days from mailing date of this letter
65a	III	105	$3	$315	15 calendar days from mailing date of this letter
82c	II	105	$5	$525	5 calendar days from mailing date of this letter
183b	II	105	$5	$525	5 calendar days from mailing date of this letter
183e	III	105	$3	$315	15 calendar days from mailing date of this letter
227g	III	105	$3	$315	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected and full compliance with the regulation has been achieved by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

Mr. Matthew Hayden

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
PH: 717-265-8942

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *THE BIRCHES AT NEWTOWN* **License #**: *14230* **License Expiration**: *09/15/2026*

Address: *70 DURHAM ROAD, NEWTOWN, PA 18940*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *CARE HSL NEWTOWN OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *06/17/2016* **Issued By**: *Newtown Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *174* **Waking Staff**: *131*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *11/07/2025*

Inspection Dates and Department Representative

10/22/2025 - On-Site: [redacted]

10/24/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served**: *109*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak* **Capacity**: *57* **Residents Served**: *50*

Hospice

Current Residents: *19*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *108*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *65*

Have Physical Disability: *1*

Inspections / Reviews

10/22/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/29/2025*

12/04/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/09/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/09/2026*

03/05/2026 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/09/2026*

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

25b - Contract Signatures

1. Requirements

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

Description of Violation

The resident-home contract, dated [redacted] for resident [redacted] was not signed by the resident. There was no indication the resident was given the opportunity to sign.

Repeat violation: [redacted] *and* [redacted] *et al*

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

Immediate Corrective Actions: This document was updated by the Executive Director to include that the resident was unable to sign on 10/22/25.
Additional Corrective Actions: The Executive Director will train the Business Office Manager by 12/15/25, to ensure all agreements are signed by residents on the day of admission, before uploading the document to the resident record.
The Executive Director and Business Office Manager will complete an audit of all current Resident Agreements by 1/9/25 to ensure all contracts include residents' signatures, or an explanation as to why they are not signed.
Ongoing Quality Assurance Actions: The Executive Director or Resident Care Director will review a 5% sample of resident records each month, as part of Quality Assurance Reviews, including verification of all required signatures on contract, beginning with the first 5% sample completed by 12/30/25. Ongoing compliance will be reviewed at Quarterly QA meetings, beginning on 1/15/26, with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented [redacted] - 03/04/2026)

42b - Abuse

2. Requirements

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

Description of Violation

On [redacted] at 5:53 AM resident [redacted] pressed [redacted] call bell signaling for staff to come to [redacted] room. When staff arrived, resident [redacted] was screaming "I'm dying, I took a bunch of pills". The resident then vomited multiple times while staff called 911. Emergency services and local police arrived. Resident [redacted] was taken to the hospital, and [redacted] room was searched. The police officer on scene located an empty bottle of [redacted] in the medicine cabinet on the bathroom wall that originally contained ten 5 mg tablets and was prescribed to the resident on [redacted]. The home also located a large bottle of 500 mg equate extra strength acetaminophen pain reliver that originally contained 500 pills. Resident [redacted] did not have a doctor's order for this strength of acetaminophen and Resident 2 has been assessed as incapable of self-administering medications.

While at the hospital, Resident [redacted] testing indicated the resident had a [redacted] toxicity level of 51.8. The hospital records also noted that resident [redacted] had two prior [redacted] attempts and a psychiatric consultation on [redacted] when [redacted]

42b - Abuse (continued)

seen for [redacted]

Resident [redacted]'s progress notes from the home indicate that on [redacted] requested to stop all non-essential medication immediately, to which the resident's physician agreed. On [redacted] resident [redacted] requested a hospice consult and stated [redacted] would not take any medication until then. On [redacted], resident [redacted] refused medications stating, "I'm a DNR" and on [redacted], resident was noted to be non-compliant with medications again. Resident 2 was signed on to hospice on [redacted] On [redacted] staff noted that resident [redacted] was more depressed and that resident asked, "to call hospice because I would like to speed up my death" and a hospice social worker was contacted. On [redacted] resident [redacted] was removed from hospice care at the resident's request.

Resident [redacted] was previously being evaluated by psychiatry in December 2023 and again in June 2024, with no indication of ongoing evaluations or additional referrals.

Direct care staff who were interviewed have reported that the resident had been more reserved, impatient and angry in the days leading up to the incident on [redacted] A direct care staff person reported to nursing staff that resident [redacted] had a bottle of [redacted] on their bathroom counter on multiple dates in the days prior to the incident., however this medication, which was not prescribed for Resident [redacted] was not removed from the resident's room upon notification by the direct care staff person. Repeat Violation Date: [redacted]

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

Immediate Corrective Actions: Executive Director and Resident Care Director did a complete sweep of resident's room on 10/16/25 to ensure there were no medications in [redacted] room, as the resident is unable to self-administer medications.
Additional Corrective Actions: All staff will be in-serviced by 12/15/25 by Resident Care Director and Executive Director on Abuse and Abuse Reporting, as well as regulations related to Medication Self-Administration and Medication Storage and how to report concerns related to these requirements to managers. Staff will also be educated on the need to report concerns and changes related to resident mood, behavior, and personality to a supervisor.
Ongoing Quality Assurance Actions: The Executive Director and Resident Care Director will review changes in status for residents at the Daily Huddle meeting, beginning 12/8/25. In addition, staff will report concerns with medications and/or storage, beginning 12/15/25. An annual review of resident rights will continue to be held with staff and residents. Ongoing compliance will be discussed at Quarterly QA meetings, beginning on 1/15/26, with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented ([redacted] - 03/04/2026)

51 - Criminal Background Check

3. 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 A, whose first day of work was [redacted], did not have a criminal background check completed.

51 - Criminal Background Check (continued)

Repeat violation [redacted] et al

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

Immediate Corrective Actions: The Executive Director immediately contacted the Staffing Agency, on 10/30/25, to get a completed copy of Staff person A's criminal background check.
Additional Corrective Actions: The Business Office Manager and all department managers will be educated by the Executive Director by 12/15/25 regarding regulatory requirements for criminal background checks and FBI checks on employees, including that no employee may begin working until it is verified this has been completed. The Business Office Manager will complete an audit of all current employees to review their records to confirm they each have a completed background check in their file. The audit will be completed by 12/15/25.
Ongoing Quality Assurance Actions: The Business Office Manager will audit a 5% sample of staff records each month as part of the Quality Assurance process to ensure clearances are completed accurately and on file, with the first 5% sample completed by 12/30/25. Findings will be reviewed at the Quarterly QA Meetings, beginning on 1/15/26, with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented [redacted] 03/04/2026)

54a - Direct Care Staff

4. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

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

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

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

Repeat Violation Date [redacted] et al.

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

Immediate Corrective Actions: The Executive Director immediately requested waivers for Staff persons A, B, and C, on 10/16/25, after verifying the education backgrounds of the staff. The staff were removed from the schedule on 10/16/25, until the waivers were received the following week.
Additional Corrective Actions: The Business Office Manager will be trained by the Executive Director by 12/15/25

54a - Direct Care Staff (continued)

that all direct care staff must have their qualifications reviewed to ensure they meet regulatory requirements prior to working with residents. The Business Office Manager will complete an audit of all current employees to review their records to confirm they each have appropriate qualifications documented in their record. The audit will be completed by 1/9/25.

Ongoing Quality Assurance Actions: The Business Office Manager will audit a 5% sample of staff records each month as part of the Quality Assurance process to ensure all educational requirements are met and on file, with the first 5% sample review completed by 12/30/25. Findings will be reviewed at the Quarterly QA Meetings, beginning on 1/15/26, with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *01/09/2026*

Not Implemented (- 03/04/2026)

62 - Contact List

5. Requirements

2600.

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

Description of Violation

Staff person D, the administrator, maintains a list of staff persons that does not include contracted agency and substitute staff.

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

Immediate Corrective Actions: The Executive Director immediately updated the information to include Staff D, agency staff member, and additional agency staff in the list of staff persons, on 10/22/25.

Additional Corrective Actions: By 12/15/25, the Executive Director will educate the Business Office Manager to ensure the list of staff persons is up to date and that all new staff through the community or the staffing agency must be added to the list prior to working with residents.

Ongoing Quality Assurance Actions: The Business Office Manager will audit the list of staff persons each month as part of the Quality Assurance, beginning 12/15/25. Findings will be reviewed at the Quarterly QA Meetings, beginning on 1/15/26, with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented - 03/04/2026)

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.

65a FS Orientation 1st Day *(continued)*

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 A, 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.

Repeat violation: [redacted] et al

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

Immediate Corrective Actions: Staff A will complete the general fire safety training with Maintenance Director by 12/15/25 and sign a training attendance sheet. This staff person was removed from the schedule and will not be scheduled to work until the training is completed.
Additional Corrective Actions: The Executive Director will train the Business Office Manager by 12/15/25 to ensure all new employees and agency employees have fire training before day one of work. BOM will have staff members sign off when training is completed. All current employee files will be audited by 12/15/25 by the BOM, to ensure they have had the training.
Ongoing Quality Assurance Actions: The Business Office Manager will audit a 5% sample of staff records each month as part of the Quality Assurance process to ensure all required training is complete and recorded, with the first 5% sample completed by 12/30/25. Findings will be reviewed at the Quarterly QA Meetings, beginning on 1/15/26, with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented ([redacted] - 03/04/2026)

65d - Initial Direct Care Training

7. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs
   iii. Personal hygiene.
   iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.

65d - Initial Direct Care Training *(continued)*

v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
vi. Implementation of the initial assessment, annual assessment and support plan.
vii. Nutrition, food handling and sanitation.
viii. Recreation, socialization, community resources, social services and activities in the community.
ix. Gerontology.
x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the home.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. Infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [redacted], began providing unsupervised ADL services on [redacted] However, the staff person did not complete training that included a demonstration of job duties, followed by supervised practice, did not complete and pass the Department-approved direct care training course and pass the competency test, and did not complete the following initial direct care staff person training: Safe management techniques, ADLs and IADLs, Personal hygiene, Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities, The normal aging-cognitive, psychological and functional abilities of individuals who are older, Implementation of the initial assessment, annual assessment and support plan, Nutrition, food handling and sanitation, Recreation, socialization, community resources, social services and activities in the community, Gerontology, Staff person supervision, if applicable, Care and needs of residents with special emphasis on the residents being served in the home, Safety management and hazard prevention, Universal precautions, The requirements of this chapter, Infection control, Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home

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

Immediate Corrective Actions: Staff A 's Direct Care Certification was provided by agency on 10/22/25, the day of the inspection.
Additional Corrective Actions: The Executive Director will train the Business Office Manager by 12/15/25 to ensure all new employees and agency employees have direct care training certification and documentation they have demonstrated their ability to perform their job duties before providing unsupervised care. BOM will audit all direct care staff employee files to ensure they have Direct Care Certification and verification they have demonstrated their ability to perform their job duties before working unsupervised, by 1/9/25.
Ongoing Quality Assurance Actions: The Business Office Manager will audit a 5% sample of staff records each month as part of the Quality Assurance process to ensure all required training is complete and recorded, with the first 5% sample completed by 12/30/25. Findings will be reviewed at the Quarterly QA Meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *01/09/2026*

Not Implemented ([redacted] - 03/04/2026)

82c - Locking Poisonous Materials

8. Requirements

2600.

82c - Locking Poisonous Materials *(continued)*

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

An aerosol spray can of Febreze and a tube of Crest toothpaste , both with a manufacturer's label indicating "if ingested call poison control", was unlocked, unattended, and accessible to residents in room [redacted]. Not all the residents of the home, including resident [redacted] have been assessed as capable of recognizing and using poisons safely.

Repeat violation [redacted], and [redacted] et al

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

Immediate Corrective Actions: The Memory Care Director immediately removed these items from the resident's room on 10/22/25. All other memory care rooms were inspected by the Memory Care Director on 10/22/25 to ensure no poisonous materials were accessible.
Additional Corrective Actions: The Memory Care Director will provide education for all staff in the Memory Care Neighborhood regarding how to identify a poisonous material and storage requirements for poisonous materials, by 12/15/25. Staff will further be trained to remove poisonous materials if found and report them to the Memory Care Director or Executive Director.
Ongoing Quality Assurance Actions: The Memory Care Director will inspect all rooms daily on [redacted] morning rounds for poisonous materials, beginning 12/15/25. The Maintenance Director will also complete a daily walk throughout the community and be vigilant for poisonous materials, beginning 12/15/25. Ongoing compliance will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented [redacted] - 03/04/2026)

85a - Sanitary Conditions

9. Requirements

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

Description of Violation

On [redacted] at 9:18 AM, there was a small trash bag leaning against the door to the Pine laundry room. The laundry room door had noticeable black residue at the bottom. Inside the laundry room there was trash, papers, old receipts and spilled laundry detergent between the washer and dryer units.

At 9:37 AM a trash bag containing soiled briefs was on the floor in front of the trash bins in the Maple laundry room.

At 9:48 AM the floor and counter in the secure dementia care unit (SDCU) Blue Kitchen was sticky. Inside the refrigerator there was spilled red juice, a broken creamer container and a brown substance located on the bottom of the inside of the fridge. On top of the fridge was an old plastic container that was greasy when touched.

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

Immediate Corrective Actions: The Memory Care Director immediately removed the trash bag that was leaning against door in laundry room, on 10/22/25. Housekeeping staff removed the debris, and cleaned the laundry door, and cleaned the area between the washer and dryer units on 10/22/25. The bag filled with trash on the floor was

85a Sanitary Conditions (continued)

placed into the trash bin by the Maintenance Director on 10/22/25. The floor and refrigerator were cleaned by housekeeping staff on 10/22/25.
Additional Corrective Actions: The Memory Care Director will in service all staff on where to properly store trash by 12/15/25. The Memory Care Director will inspect all laundry rooms daily on [redacted] morning rounds, beginning 12/15/25.
Ongoing Quality Assurance Actions: The Maintenance Director will do a daily walk throughout the community, including laundry rooms, beginning 12/15/25. Ongoing compliance will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Implemented ([redacted] - 03/05/2026)

85b - Infestation

10. Requirements

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

Description of Violation

On [redacted] 9:48 AM, there was at least 3 flies swarming around the juice machine and there were more flies flying above an uncovered oatmeal container and a full uncovered trash can in the SDCU Blue Kitchen.

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

Immediate Corrective Actions: Direct Care Staff immediately removed the uncovered oatmeal container and placed lid on trash can, on 10/22/25. Dining staff cleaned the area around the juice machine on 10/22/25.
Additional Corrective Actions: The Memory Care Director and Dining Service Director will in service all staff on proper food and trash storage and the need to be vigilant for areas needing cleaning by 12/15/25.
Ongoing Quality Assurance Actions: The Memory Care Director and Dining Director will inspect the dining room and kitchenettes daily, as part of their daily inspections, beginning 12/15/25. Findings from daily inspections will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Implemented [redacted] 03/05/2026)

85d - Trash Receptacles

11. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [redacted] at 9:48 AM there was a 3/4 full, uncovered, unattended trash can with food, disposable cups, and napkins in the SDCU blue kitchen. No staff persons were present in the kitchen at the time.

Repeat Violation: [redacted] et al.

85d - Trash Receptacles *(continued)*

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

Immediate Corrective Actions: Trash lids were secured on trash cans by the Memory Care Director and Dining Services Director on 10/22/25. All other trash cans in Memory Care were confirmed to have lids by the Memory Care Director on 10/22/25.
Additional Corrective Actions: The Memory Care Director and Dining Service Director will in service all staff on regulatory sanitation requirements regarding trash can lids by 12/15/25, including that staff will replace lids when trash cans are not in use, and will report any trash cans missing lids.
Ongoing Quality Assurance Actions: The Memory Care Director and Dining Director will inspect dining room trash can lids in kitchenettes daily, beginning 12/15/25. Findings from daily inspections will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Implemented [redacted] - 03/05/2026)

100a - Exterior - Free of Hazards

12. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On [redacted] at 9:36 AM, outside of the main dining room exit, there were old rags, discarded plastic gloves, and a wet upholstered chair.

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

Immediate Corrective Actions: Debris outside the door was discarded by the Memory Care Director, on 10/22/25.
Additional Corrective Actions: The Memory Care Director and Dining Service Director will in-service all staff on regulatory sanitation requirements regarding proper disposal of trash and debris by 12/15/25.
Ongoing Quality Assurance Actions: The Memory Care Director will complete a daily walk of the Memory Care Neighborhood, beginning 12/15/25. The Maintenance Director will complete a daily walk of the interior and exterior of the community, beginning 12/15/25. Findings from daily inspections will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented [redacted] - 03/04/2026)

101o - Walls, Floors, Ceilings

13. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On [redacted], the carpet in bedroom [redacted] had a large brownish/black stain in the entrance way.

The carpet in bedroom [redacted] had a large brownish/black stain on the left side of the bed.

101o - Walls, Floors, Ceilings (continued)

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

Immediate Corrective Actions: Carpets in bedrooms and were immediately removed and cleaned by the Maintenance Director on 10/22/25.
Additional Corrective Actions: The Maintenance Director will in-service all maintenance and housekeeping staff on properly reporting carpets that need to be cleaned by 12/15/25. In addition, the Maintenance Director will check all resident rooms by 1/9/26 to ensure the carpets are clean and free from stains.
Ongoing Quality Assurance Actions: The Maintenance Director will do monthly checks of all resident rooms carpets to ensure all carpets remain clean and free from stains, beginning 1/9/26. Findings from inspections will be reviewed at the Quarterly QA meetings beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented - 03/04/2026)

103c - Food Protected

14. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On at 9:48 AM there was an uncovered metal container of dried out oatmeal with several flies flying above it in the Blue Kitchen in the SDCU.

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

Immediate Corrective Actions: Direct Care Staff immediately removed the uncovered oatmeal container on 10/22/25.
Additional Corrective Actions: The Memory Care Director and Dining Service Director will in-service all staff on proper food storage by 12/15/25. The Memory Care Director and Dining Services Director will inspect dining room kitchenettes daily, beginning 12/15/25 and any evidence of flies will be reported to Maintenance Director. The Maintenance Director will ensure pest control is notified if needed for additional support.
Ongoing Quality Assurance Actions: The Maintenance Director will complete daily walks throughout the community, beginning 12/15/25. Findings from daily inspections will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Implemented 03/05/2026)

105g - Lint Removal and Duct Cleaning

15. Requirements

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

105g - Lint Removal and Duct Cleaning *(continued)*

Description of Violation

On [redacted], there was an approximate 1/2-inch accumulation of lint in the lint trap of each dryer in each of the laundry rooms in the Pine, Maple, and Sycamore areas. There were no clothes in any of the dryers at the time.

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

Immediate Corrective Actions: The Maintenance Director immediately removed lint from all dryers on 10/22/25.
Additional Corrective Actions: The Maintenance Director will provide education for all staff regarding fire safety and the need to remove lint from dryers immediately following use. This training will be completed by 12/15/25.
Ongoing Quality Assurance Actions: The Maintenance Director/ Maintenance Assistant will do checks of all dryers' lint traps to ensure there is no lint in traps on a daily basis, beginning 12/15/25. Findings from daily inspections will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented [redacted] - 03/04/2026)

125a - Combustible Storage

16. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On [redacted] at 9:16 AM there were stacks of cardboard boxes stored directly next to the two HVAC systems in the maintenance closet on the second floor.

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

Immediate Corrective Actions: The Maintenance Director immediately removed the stacks of cardboard boxes on 10/22/25.
Additional Corrective Actions: The Executive Director will provide education for all maintenance and housekeeping staff regarding regulatory requirements related to storage and heat sources. This will be completed by 12/15/25.
Ongoing Quality Assurance Actions: The Maintenance Director/ Maintenance Assistant will do daily audits of storage areas to ensure there are no combustible/ flammable materials located near heat sources or hot water heaters, beginning 12/15/25, as part of the daily community walk through. Findings from daily inspections will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented [redacted] - 03/04/2026)

141b1 - Annual Medical Evaluation

17. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

Resident [redacted]'s most recent medical evaluation was completed on [redacted] however it was completed on an obsolete form that the Department discontinued in July 2025. The resident's previous medical evaluation was completed on [redacted].

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

Immediate Corrective Actions: The Resident Care Director contacted the PCP to ensure the correct DME is filled out on behalf of the resident, on 10/22/25. The updated form was obtained and uploaded into the resident record on 10/22/25.
Additional Corrective Actions: The Resident Care Director in-serviced the Memory Care Director and Marketing Director on 11/28/25 to ensure all DMEs are filled out on the proper, updated DME form that has been approved by the Department. By 12/15/25, The Resident Care Director will do an audit of all current DMEs since July 2025 to ensure they are all on the Department's current approved form.
Ongoing Quality Assurance Actions: The Resident Care Director will review a 5% sample of resident records each month, including verification that the state required forms are used, with the first 5% sample completed by 12/30/25. Findings will be reviewed at Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented [redacted] - 03/04/2026)

162c - Menus Posted

18. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On [redacted], the home's menu for the week of [redacted] was posted. However, the menu for the following week was not posted.

Repeat violation: [redacted] et al

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

Immediate Corrective Actions: The Dining Director immediately posted two weeks of menus on 10/22/25.
Additional Corrective Actions: The Dining Service Director was educated by the Executive Director on 10/22/25 regarding the regulatory requirements for posting two weeks of menus.
Ongoing Quality Assurance Actions: The Dining Service Director will post a two-week menu at end of the day on Fridays, beginning the week of 10/27/25, and will do a daily walk through of the dining area to ensure the menus remain posted. Ongoing compliance and findings will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

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

Not Implemented [redacted] - 03/04/2026)

182b - Prescription Medication

19. 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 [redacted] to [redacted], staff person B administered medications to residents to include the following: [redacted] mg tablet to resident [redacted]
Staff person B 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.

Staff person B's initial medication technician training was completed on 4/6/2024 but staff person B does not meet the qualifications to be a direct care staff person and has also not completed an annual practicum for the medication administration program as required.

On [redacted] at 8:36 PM staff person C administered medications to residents to include the following: [redacted] tablet and [redacted] to resident [redacted] Staff person C 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.

Staff person C completed medication administration certification [redacted] on a paper form which became obsolete [redacted]. Additionally, Staff person C does not meet the qualifications to be a direct care staff person.

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

Immediate Corrective Actions: Staff Persons B & C completed the full medication administration training as specified in § 2600.190 on 11/14/25, to ensure they meet the qualifications for the medication administration program as required.
Additional Corrective Actions: The Executive Director educated the Resident Care Director on the requirements of the Medication Administration Program on 10/22/25. The Resident Care Director instructed all Med Techs to re-take the full medication administration training as specified in § 2600.19 to ensure they meet the qualifications for the medication administration program as required. The Resident Care Director will verify they have completed it and review all documentation to confirm training was completed by 11/14/25.
Ongoing Quality Assurance Actions: The Resident Care Director will ensure all Med Techs Certifications/Qualifications are up to date, including annual practicum and observation requirements, beginning 10/22/25. Ongoing compliance will be reviewed at Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

182b - Prescription Medication (continued)

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

Implemented (- 03/04/2026)

183b - Meds and Syringes Locked

20. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On at 9:21 AM, nystatin cream and triamcinolone acetonide cream were found unlocked, unattended, and accessible in resident room. Resident is assessed as not capable of self-administrating medications.

At 9:39 AM, deep sea nasal spray, toothache gel, and biotin were observed to be unlocked, unattended, and accessible in room

Repeat violation.

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

Immediate Corrective Actions: The items were removed by the Resident Care Director on 10/22/25.
Additional Corrective Actions: All Med Techs and Direct Care Staff will be educated by the Resident Care Director by 12/15/25 to ensure all prescriptions medications, OTC medications, CAM and syringes must be kept in a container that is locked, including in resident rooms, as well as the expectation to remove any unlocked items and report them to the Resident Care Director or Memory Care Director. All resident rooms were inspected by the Executive Director, Resident Care Director, and Memory Care Director on 10/22/25, to ensure there were no other unlocked medications.
Ongoing Quality Assurance Actions: The Resident Care Director and the Memory Care Director will visually inspect all residents' rooms weekly beginning 12/1/25 and will immediately correct any concerns that are found. Ongoing compliance will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented (- 03/04/2026)

183d - Prescription Current

21. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On and prescribed for resident , were in the resident's room; however, these medications were both discontinued on

183d - Prescription Current *(continued)*

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

Immediate Corrective Actions: Discontinued prescription items were removed by the Resident Care Director on 10/22/25.
Additional Corrective Actions: All Med Techs and Direct Care Staff will be educated by the Resident Care Director by 12/15/25 to ensure only current physician-ordered prescription medications, OTC medications, CAM and syringes are on hand and must be kept in a container that is locked, including in resident rooms, as well as the expectation to remove any discontinued medications and report them to the Resident Care Director or Memory Care Director. All resident rooms were inspected by the Executive Director, Resident Care Director, and Memory Care Director on 10/22/25, to ensure there were no other discontinued medications.
Ongoing Quality Assurance Actions: Weekly Medication Cart Audits will be completed by Med Techs, beginning 12/15/25 to ensure only current medications are on the cart. The Resident Care Director and the Memory Care Director will visually inspect all residents' rooms weekly beginning 12/15/25 and will immediately remove any discontinued medications that are found. Ongoing compliance will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented [redacted] - 03/04/2026)

183e - Storing Medications

22. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [redacted], was found in medicine cabinet of room [redacted] According to the manufacturer's instructions this expired [redacted].

Repeat violation: [redacted], and [redacted] et al

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

Immediate Corrective Actions: The Vick's Vaporub was immediately removed by the Resident Care Director on 10/22/25.
Additional Corrective Actions: All Med Techs and Direct Care Staff will be educated by the Resident Care Director by 12/15/25 to ensure prescription medications, OTC medications, CAM and syringes are not expired, including in resident rooms, as well as the expectation to remove any expired medications and report them to the Resident Care Director or Memory Care Director. All resident rooms were inspected by Executive Director, Resident Care Director and Memory Care Director on 10/22/25, to ensure there were no other expired medications.
Ongoing Quality Assurance Actions: Weekly Medication Cart Audits will be completed by Med Techs, beginning 12/15/25 to ensure no expired medications are on the cart. The Resident Care Director and the Memory Care Director will visually inspect all residents' rooms weekly beginning 12/15/25 and will immediately remove any expired medications that are found. Ongoing compliance will be reviewed at the Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

183e - Storing Medications *(continued)*

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented [redacted] - 03/04/2026)

227c - Support Plan Revision

23. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

On [redacted] at 7:00 PM resident [redacted] was found with [redacted] walker next to resident [redacted], in resident [redacted] apartment doorway. Resident [redacted] was laying on the ground and had a skin tear on their upper right arm requiring treatment at a hospital. Staff reported that resident [redacted] often gets over worked in large groups and will attempt to strike other residents with [redacted] walker.

Resident [redacted]s most recent assessment was completed on [redacted], stating that resident [redacted] can become agitated due to confusion or not being able to complete tasks, is easily agitated and can become very restless, and periods of profanity and attitude may be present. An addendum, added [redacted], stating "[Resident [redacted] had a verbal altercation in the hallway with another resident. [Resident 3] reached out and swiped the other resident in the face and made a small scratch." Resident [redacted] support was not actually updated, only a description of the incident was noted stating: DCS staff were nearby and was able to redirect resident away from the other resident. DCS was able to calm them down and took them back to their own room.

Resident [redacted] support plan has not been updated to address how staff will meet the needs of the resident's physical aggression towards other residents.

Repeat violation: [redacted] et al

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

Immediate Corrective Actions: The Resident Care Director will update Resident [redacted] support plan to include how staff will meet the needs of the resident and provide support to manage their physical aggression towards other residents. This will be completed by 12/15/25.
Additional Corrective Actions: The Executive Director will provide education to Resident Care Director and Memory Care Director by 12/15/25 on how to complete and update RASPs, to address all care needs, including behavioral supports. An audit of all support plans will be completed by the Resident Care Director by 1/9/26 for accurate and specific details tailored to the residents' needs.
Ongoing Quality Assurance Actions: The Resident Care Director will review a 5% sample of resident records each month, including verification that the RASP is updated and addresses care needs appropriately, with the first 5% sample completed by 1/9/26. Findings will be reviewed at Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

227c - Support Plan Revision (continued)

Licensee's Proposed Overall Completion Date: *01/09/2026*

Not Implemented [redacted] - 03/04/2026)

227g -Support Plan Signatures

24. 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.

Repeat violation: [redacted]

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

Immediate Corrective Actions: The Resident Care Director reviewed the RASP and the resident signed the support plan on 10/22/25.
Additional Corrective Actions: The Resident Care Director and Memory Care Director will be in-serviced by the Executive Director by 12/15/25 to ensure everyone who participates in developing and reviewing RASPs signs them or notes why they did not sign. The Resident Care Director and Memory Care Director will complete an audit of all current RASPs by 12/15/25 to ensure all support plans have signatures by everyone involved.
Ongoing Quality Assurance Actions: The Resident Care Director and Memory Care Director will review a 5% sample of resident records each month as part of Quality Assurance Reviews, to ensure RASPs are signed by all who participate in developing and reviewing them, with the first 5% sample completed by 12/30/25. Ongoing compliance will be reviewed at Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented[redacted] - 03/04/2026)

231b - Medical Evaluation

25. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident's medical evaluation was completed on [redacted]

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

Immediate Corrective Actions: Resident Care Director had PCP update the current DME on 10/22/25.
Additional Corrective Actions: By 12/15/25, the Executive Director will in-service the Resident Care Director and the Memory Care Director on the timelines for DME completion for both personal care and memory care, and the

231b Medical Evaluation (continued)

difference between them. The Resident Care Director and Memory Care Director will review all current DMEs to ensure they were completed within the regulatory timelines, by 12/15/25.
Ongoing Quality Assurance Actions: The Resident Care Director and Memory Care Director will review a 5% sample of resident records each month as part of Quality Assurance Reviews, to ensure DMEs are current and completed within regulatory guidelines, with the first 5% sample completed by 12/30/25. Ongoing compliance will be reviewed at Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented [redacted] - 03/04/2026)

231c - Preadmission Screening

26. Requirements

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

Description of Violation

Resident [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident [redacted] written cognitive preadmission screening was not completed.

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

Immediate Corrective Actions: The Resident Care Director contacted the PCP to ensure the cognitive screening is filled out on behalf of the resident, on 10/22/25. The updated form was obtained and uploaded into the resident record on 10/22/25.
Additional Corrective Actions: The Resident Care Director will in service the Memory Care Director regarding the cognitive screening form and timeline for completion, by 12/15/25. The Resident Care Director and Memory Care Director will review all current cognitive screenings to ensure they were completed timely and are in the resident record, by 12/15/25.
Ongoing Quality Assurance Actions: The Resident Care Director and Memory Care Director will review a 5% sample of resident records each month as part of Quality Assurance Reviews, to ensure cognitive screenings are current and completed within regulatory guidelines, with the first 5% sample completed by 12/30/25. Ongoing compliance will be reviewed at Quarterly QA meetings, beginning on 1/15/26 with a review of Q42025 (October, November, and December 2025).

Licensee's Proposed Overall Completion Date: *12/15/2025*

Not Implemented [redacted] - 03/04/2026)

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

Facility Information

Name: *THE BIRCHES AT NEWTOWN* **License #**: *14230* **License Expiration**: *09/15/2026*

Address: *70 DURHAM ROAD, NEWTOWN, PA 18940*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *CARE HSL NEWTOWN OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *06/17/2016* **Issued By**: *Newtown Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *164* **Waking Staff**: *123*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *01/08/2026*

Inspection Dates and Department Representative

01/08/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served**: *105*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak* **Capacity**: *57* **Residents Served**: *44*

Hospice

Current Residents: *14*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *105*

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

Have Mobility Need: *59* **Have Physical Disability**: *1*

Inspections / Reviews

01/08/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/14/2026*

02/18/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/27/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/09/2026*

03/05/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/27/2026*

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

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted] around 10:45 AM, the assignment sheet for the home's Juniper Hallway, which contained a list of resident names and the ADL assistance needed for each resident, was unlocked, unattended, and accessible.

Repeat Violation: [redacted]

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions - The assignment sheets were immediately removed from the storage area on 1/8/2026 by the executive Director.

Additional Corrective Actions - The Resident Care Director, Memory Care Director, Resident Care Coordinator, and Wellness supervisor were re-educated 1/21/26 by the Executive Director on DHS regulation 2600.17.a, and all staff will be in-serviced by 2/27/26 to ensure that resident records are kept confidential and not accessible to the public. The RCD and MCD will audit all public access areas daily for 2 weeks, then 3 X weekly for 2 weeks to ensure that assignment sheets and resident confidential information are kept protected. Audit completion date will be 3/27/26.

Ongoing Quality Assurance Actions - The Maintenance Director, Resident Care Director, and Memory Care Director will each round the community once daily beginning 2/16/26 to monitor and ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q1 2026 -January, February, and March-in April 2026.) The Resident Care Director is responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented ([redacted] - 03/04/2026)

51 - Criminal Background Check

2. 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 A, whose 1st day of work at the home was [redacted] and worked most recently on [redacted], does not reside in the state of Pennsylvania; however, the home has not run the Federal Bureau of Investigation (FBI) background check 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).

Repeat Violation: [redacted] *et al.*

51 - Criminal Background Check *(continued)*

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions - All Department Directors were re-educated on 1/28/26 by the Executive Director on DHS regulation 2600.51 to ensure that all employees and agency staff criminal background checks are completed prior to the first day of employment.

Additional Corrective Actions - The Business Office Director (BOD) will audit all employees and agency staff files to ensure that FBI checks were completed prior to first day of employment by 2/27/26. Then, MCD and/or RCD will audit agency records weekly X 4 weeks to ensure that any new agency staff member FBI records have been completed and stored in an agency binder. Audits for 2600.51 will be completed by 3/27/26.

Ongoing Quality Assurance Actions – The BOD will audit a 5% sample of employees and agency records each month to ensure that all required items are in staff files beginning March 2026. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q1 2026 – January, February, and March-in April 2026.
The Business Office Director is responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented ([redacted] - 03/04/2026)

54a - Direct Care Staff

3. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Staff person A, whose 1st day of work at the home was [redacted], does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Repeat Violation: [redacted] *et al.*

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions - The Department Directors were re-educated 1/21/26 by the Executive Director on DHS regulation 2600.54a to ensure that direct care staff and agency staff have a high school diploma, GED or active CNA registry.

Additional Corrective Actions - The RCD, MCD and/or BOD will audit all direct care employee and agency staff files to ensure they have high school diplomas, GED's or active CNA registry's by 2/27/26.
The MCD and/or RCD will audit new agency employee records weekly X 4 weeks to ensure that any new agency staff member high school diplomas have been received and stored in an agency binder. Binder implementation for agency staffing will begin 2/20/26.
The BOD will audit new employee records weekly X 4 weeks to ensure that any new employees high school diplomas have been received and stored in the employees' file. Audits will be completed by 3/27/26.

Ongoing Quality Assurance Actions – The BOD will audit a 5% sample of employees and agency records each

54a Direct Care Staff (continued)

month to ensure that all required items are in staff files. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 January, February, and March in April 2026.
BOD is responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/04/2026)

62 - Contact List

4. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person B, the administrator, does not maintain a current list of the names, addresses and telephone numbers of substitute personnel.

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions The BOM, Resident Care and Memory Care Directors were re educated 2/6/26 by the Executive Director on DHS regulation 2600.62 to ensure that the community maintains a current list of names, addresses, and telephone numbers of substitute personnel.

Additional Corrective Actions The ED and/or the AED will create a list of all staff person's names, addresses and phone numbers including substitute/agency personnel and volunteers, by 2/27/26. This list will be available the RCD office.
The AED will audit contact list weekly x 4 weeks to ensure ongoing compliance. Audits will be completed by 3/27/26.

Ongoing Quality Assurance Actions The Assistant Executive Director will audit this list monthly, to ensure it is up to date and accurate for all staff. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q1 2026 January, February, and March in April 2026.
The AED is responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented ([redacted] - 03/04/2026)

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

On [redacted] around 09:30 AM, following items with a manufacturer's label indicating "If swallowed or If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away", were unlocked, unattended, and accessible to residents:
Sensodyne Pronamel toothpaste and Colgate optic white tooth paste in room 6.

82c - Locking Poisonous Materials (continued)

[redacted] and [redacted] toothpaste in room [redacted]
-Suave deodorant in room 33
-Nourish toothpaste and Aqua fresh in resident [redacted] room

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

Repeat Violation: [redacted] et al.

Plan of Correction ***Accept ([redacted] - 02/18/2026)***

Immediate Corrective Actions -The MCD and RCD rounded all residents' rooms immediately after the violation was identified and removed the poisonous items. All Department Directors and direct care staff were re-educated 1/21/26 by the Executive Director and AED on DHS regulation 2600.82.c to ensure that all poisonous materials shall be kept locked and inaccessible to residents who are unable to safely use or avoid poisonous materials.

Additional Corrective Actions - The RCD, MCD and Wellness Nurse will audit all resident apartments by 2/20/26 to ensure all poisonous items are stored appropriately and secured. Then, MCD and/or RCD will audit resident apartments twice a week X 4 weeks to ensure that no poisonous materials are in resident rooms. Weekly audits will end 3/27/26.

Ongoing Quality Assurance Actions – The Assistant Executive Director, Memory Care Director, and Resident Care Director will each round the community once daily to monitor that all poisonous materials are stored appropriately and secured, beginning 2/16/26. Ongoing compliance will be reviewed at Quarterly QA Meetings, beginning with a review of Q1 2026 – January, February, and March-in April 2026.
MCD and RCD are responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/04/2026)

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

On [redacted] at 9:55 AM, the floors and cabinets in the home's Red kitchen were observed to be covered with a sticky film under the juice machine. The refrigerator was also dirty with a dried yellow substance at the bottom.

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions – On 1/8/26, prior to the surveyor's departure, the floor and refrigerator were cleaned. The Directors and wellness team were re-educated 1/21/26 by the Executive Director and AED on DHS regulation 2600.85a to ensure that sanitary conditions shall be maintained.

Additional Corrective Actions - The Maintenance Director and/or designee will audit the community by 2/20/26 to

85a - Sanitary Conditions (continued)

ensure that the community meets all sanitary conditions. The Maintenance Director will complete walk through 2 x weekly x 4 weeks to ensure that sanitary conditions are maintained. Audits will be completed by 3/27/26.

The Director of Maintenance is responsible for sustained compliance.
Ongoing Quality Assurance Actions – The Maintenance Director will round the community daily to ensure sanitary conditions are maintained. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 03/04/2026)

85d - Trash Receptacles

7. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [redacted] at 10:00 AM, the trash can in the dining server area was not covered and not in use. It was halfway full with food debris and papers. Kitchen staff said that no closing lid had ever existed for this trash can.

Repeat Violation: [redacted] et al.

Plan of Correction ***Accept ([redacted] - 02/18/2026)***

Immediate Corrective Actions – On 1/8/26, prior to the surveyor's departure the receptacle in the dining server area was discarded.
The Directors and dining team were in-serviced 1/21/26 by the Executive Director and AED on DHS regulation 2600.85d to ensure that trash receptacles in kitchens and bathrooms shall be kept in covered receptacles.

Additional Corrective Actions - The Maintenance Director and Dining Director will audit all trash receptacles in bathrooms and kitchens by 2/20/26 and replace any receptacle that is out of compliance. Audit will be completed by 3/27/26.

Ongoing Quality Assurance Actions – The Dining Director will round the kitchen daily to ensure that receptacles are covered. The maintenance Director, MCD and RCD will round 5% of the community's bathrooms to ensure that the receptacles have lids. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.
The Maintenance and Dining Directors are responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 03/05/2026)

85e - Trash Outside Home

8. Requirements

85e - Trash Outside Home *(continued)*

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [redacted] at 10:04 AM, the two dumpsters in the back fenced-in area were observed uncovered, and they were surrounded by trash such as bottles, gloves, trash bags, and pieces of plastic.

Plan of Correction ***Accept [redacted] 02/18/2026)***

Immediate Corrective Actions – On 1/8/26, prior to the surveyor's departure the debris was cleaned from around the dumpster and the lids were closed.
The Directors and associates were in-serviced 1/21/26 by the Executive Director and AED on DHS regulation 2600.85e to ensure that outside trash is disposed of in covered receptacles to prevent penetration of insects and rodents.

Additional Corrective Actions - The Maintenance Director will audit receptacles daily X 4 weeks to ensure that all trash is placed inside of the receptacles and that they are covered. Audits will be completed by 3/27/26.

Ongoing Quality Assurance Actions – The Maintenance Director will monitor the receptacles and the exterior of the community daily. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.
The Maintenance is responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 03/05/2026)

103c - Food Protected

9. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On [redacted] at 09:20 AM, there was an uncovered metal container of oatmeal in the home's Blue dining room. At this time, there was no meal being served for residents in this dining area.

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions - The Dining Director and Executive Director audited all food prep areas on 1/8/26 to ensure that all food items were protected. The oatmeal was immediately discarded at the time of survey.
The Directors and dining team were re-educated 1/21/26 by the Executive Director and AED on DHS regulation 2600.103.c to ensure that all food shall be protected from contamination while being stored, prepared, transported and served.

Additional Corrective Actions - The Dining Director will audit food prep areas, refrigerators and freezers daily x 4 weeks to ensure that all foods are protected and covered. Audits will be completed by 3/27/26.

Ongoing Quality Assurance Actions – The Dining Director will round and monitor all food preparation areas daily

103c - Food Protected (continued)

to ensure that all food items are protected from contamination while being stored, prepared transported and served. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.
Dining Director is responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 03/05/2026)

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 [redacted] at 09:26 AM, the keypads near door #40 and door #10 inside the home's Secured Dementia Care Unit (SDCU) were not working properly. When the code was entered and the light lit green, the door would not open, blocking egress from the home's SDCU.

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions – On 1/8/26 Fusion Factors was called into the community to repair doors10 and 40. Door 10 was repaired on 1/8/26, on the day of inspection. The keypad for door #40 was malfunctioning, new part was ordered on 1/8/26, repair and test for proper operation were completed on 1/12/2026. There has been no further issues since.

The Directors and Maintenance Tech were re-educated 1/21/26 by the Executive Director and AED on DHS regulation 2600.121a to ensure that all egress doors are unobstructed.

Additional Corrective Actions - The Maintenance Director and or Maintenance Tech will audit all egress doors by 2/20/26, then monitor doors weekly to ensure that they all are fully operational. Audits will be completed by 3/27/26.

Ongoing Quality Assurance Actions – The Maintenance Director will test all egress doors weekly. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.
The Maintenance Director is responsible for sustained compliance.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 03/05/2026)

125a - Combustible Storage

11. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

125a Combustible Storage *(continued)*

Description of Violation

On [redacted] around 10:00 AM, two cardboard boxes of gloves were stored in the home's mechanical room. The boxes were observed touching the forced air unit, which was warm to the touch.

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions The box of gloves was Immediately removed from the mechanical room on 1/8/26 by the Maintenance Director. The Maintenance Director inspected all areas with heating sources on 1/8/26 to ensure that there were no combustible items present.

Additional Corrective Actions The Directors and Maintenance Tech were re educated 1/21/26 by the Executive Director and AED on DHS regulation 2600.125a to ensure that there are no combustible materials near any heating source. The Maintenance Director will audit heating source areas weekly x 4. Audits will be completed by 3/27/26.

The Maintenance Director is responsible for sustained compliance.

Ongoing Quality Assurance Actions The Maintenance Director will inspect all areas with heating sources weekly to ensure that there are no combustible items present. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 January, February, and March in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/05/2026)

131f - Fire Extinguisher Inspection

12. Requirements

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

Description of Violation

The fire extinguishers by room [redacted] and [redacted] were last inspected in October 2024. The home's fire extinguishers were last inspected on [redacted] and according to the report dated [redacted], 30 out of the 38 fire extinguishers failed the inspection and needed to be replaced; however, the home has not ordered replacements yet.

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions The Maintenance Director and Maintenance Tech were re educated on 1/21/26 by the Executive Director and AED on DHS regulation 2600.131.f to ensure that all fire extinguishers are inspected and fully operationally. On 1/22/26 the extinguishers were replaced and or recharged by Tustin Fire Solutions.

Additional Corrective Actions The Maintenance Director will audit all fire extinguishers monthly, noting date of inspection on fire extinguisher tag, to ensure all extinguishers are fully operational.
The Maintenance Director is responsible for sustained compliance.

Ongoing Quality Assurance Actions The Maintenance Director will monitor Fire extinguishers monthly to ensure that all extinguishers are inspected and operational. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 January, February, and March in April 2026.

131f - Fire Extinguisher Inspection *(continued)*

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] - 03/05/2026)

141a 1-10 Medical Evaluation Information

13. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident [redacted] medical evaluation, dated [redacted], is checked yes in section 14 for: Does the resident require dementia related care in a secured area, however, this resident does not reside in SDCU.

Resident [redacted] medical evaluation, dated [redacted] is checked yes in section 14 for: Does the resident require dementia related care in a secured area. This resident does not require dementia related care in a secure unit as the resident resides in the home's SDCU solely to be with their spouse. Additionally, in the Medical Professional information section, it is not answered if the resident's needs can be met safely at the personal care home.

Plan of Correction ***Accept ([redacted] - 02/18/2026)***

Immediate Corrective Actions – The RCD, MCD and Sales Director were re-educated 1/21/26 by the Executive Director and AED on DHS regulation 2600.141.a to ensure that documentation of medical evaluations are completed accurately according to the resident's needs.

Additional Corrective Actions - New DME's will be completed for Residents 3 and 4 by 2/27/26. The RCD and MCD will audit all residents DME's by 2/27/26 to ensure accuracy. Then, MCD and/or RCD will audit new DME's weekly X 4 weeks to ensure ongoing accuracy. Audits will be completed by 3/27/26.
MCD and RCD are responsible for sustained compliance.

Ongoing Quality Assurance Actions – The RCD will audit a 5% sample of residents DME's each month to ensure that all required items are documented correctly on the DME's. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.

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

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/05/2026)

141b1 - Annual Medical Evaluation

14. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [redacted] most recent annual medical evaluation completed on [redacted] does not include (9) immunization history, (10) body positioning/movement/level of assistance for ambulation or transfers, (11) Health status, (12) cognitive functioning, and (14) Special Care Needs (when the resident resides in the home's SDCU). These parts of the form are blank. On Medical Professional information section, it is not answered if the resident's needs can be met safely at the personal care home.

Repeat Violation:[redacted]

Plan of Correction ***Accept[redacted] - 02/18/2026)***

Immediate Corrective Actions The RCD, MCD and Sales Director were re educated 1/21/26 by the Executive Director and AED on DHS regulation 2600.141.b to ensure that documentation of medical evaluations is completed accurately, ensuring that no areas are left blank.
Additional Corrective Actions A new DME will be completed for Resident #5 by 2/27/26.
The RCD and MCD will audit all residents DME's by 2/27/26 to ensure completion. Then, MCD and/or RCD will audit new DME's weekly X 4 weeks to ensure ongoing accuracy. Audits will be completed by 3/27/26.
MCD and RCD are responsible for sustained compliance
Ongoing Quality Assurance Actions The RCD will audit a 5% sample of residents DME's each month to ensure that all required information is documented correctly on the DME's. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 January, February, and March in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] 03/05/2026)

183b - Meds and Syringes Locked

15. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On [redacted] between 10:10 AM and 10:40 AM, the following prescription and OTC medications were unlocked, unattended, and accessible:
a tube of [redacted] Cream apply rectally as needed in room [redacted] and [redacted] and [redacted] in room [redacted] and [redacted] in room [redacted]

183b - Meds and Syringes Locked (continued)

- [redacted] and [redacted] in room [redacted]
- [redacted] in room [redacted]
[redacted] prescribed for resident [redacted] in the medication room cabinet

Repeat Violation: [redacted]

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions - On 1/8/26, the RDC and MCD rounded residents' rooms; medications were secured/ locked away or removed for resident safety.
The Directors, and Med Techs were re-educated on 1/21/26 by the Executive Director and the AED on DHS regulations 2600.183b to ensure that prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked.

Additional Corrective Actions - The RCD, MCD, or Wellness Nurse will audit resident's rooms 3 x weekly for 2 weeks, then 2 x weekly x 2 weeks to ensure medications are kept secured. Audits will be completed by 3/27/26.
RCD and MCD are responsible for sustained compliance.

Ongoing Quality Assurance Actions – The RCD and MCD will round resident's rooms each week to ensure that medications are secured in resident's rooms who can self-medicate, and removed from residents who are unable to self-administer. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/05/2026)

183d - Prescription Current

16. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted] [redacted] irrigation solution prescribed for resident [redacted] was in the home's 1st floor medication cabinet; however, the resident was discharged from the home on [redacted].
A[redacted] pen prescribed for resident [redacted] was in the home's 2nd floor medication cart; however, this medication was discontinued on [redacted]

Plan of Correction ***Accept [redacted] 02/18/2026)***

Immediate Corrective Actions - Medication for resident #5 was removed by the ED and medication for resident #8 was removed by the RCD and discarded on 1/8/26.
The Directors, and Med Techs were re-educated on 1/21/26 by the Executive Director and the AED on DHS regulations 2600.183d to ensure that only current prescriptions, OTC medications, and CAM for residents living in the home are kept in the community.

Additional Corrective Actions - The Med Techs will audit Med Carts and cabinets by 2/27/26, then weekly X 4

183d - Prescription Current (continued)

weeks, to ensure only current prescriptions are kept in the community. Audits will be completed by 3/27/26. RCD is responsible for sustained compliance.

Ongoing Quality Assurance Actions – The RCD and Wellness Nurse will review the med cart audits weekly to ensure that all medications are current. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] 03/05/2026)

183e - Storing Medications

17. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [redacted] one loose red pill was observed in the home's SDCU medication cart #2.

The following expired medications were observed in the home's medication carts:
resident [redacted]
resident [redacted]
resident [redacted]
resident [redacted]
resident [redacted] and a second bag expired [redacted]

The following medication blister package cards were observed to be torn on the back:
resident [redacted]s' blister pack of [redacted] torn at blister spot 16
resident #[redacted] blister pack of [redacted] at blister spot 14

Repeat Violation: [redacted] et al.

Plan of Correction ***Accept[redacted] 02/18/2026)***

Immediate Corrective Actions - The expired medications and the loose pill were immediately removed from the cart, the med punch cards/ medications that were identified with torn backing were wasted at the time of inspection, on 1/8/26.
The Directors and Med Techs were re-educated on 1/21/26 by the Executive Director and the AED on DHS regulations 2600.183e to ensure that prescription medications, OTC medications, and CAM will be stored in an organized manner in accordance with the manufacturer's instructions.

Additional Corrective Actions - The Med techs will audit Med Carts by 2/27/26, then weekly X 4 weeks, to ensure that medications are stored properly. Audits will be completed by 3/27/26.

183e Storing Medications (continued)

RCD is responsible for sustained compliance.

Ongoing Quality Assurance Actions The RCD and Wellness Nurse will review med cart audits each month to ensure that all medications are current. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 January, February, and March in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/05/2026)

184a - Resident's Meds Labeled

18. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for a box of [redacted] was peeled off and Ipratropium [redacted] solution vials belonging to resident [redacted] was observed inside the box.

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions The albuterol was discarded by the RCD on 1/8/26
The RCD, MCD, Wellness Nurse and Med Techs were re educated on 1/21/26 by the Executive Director and the AED on DHS regulations 2600.184a to ensure that the original container for prescription medications shall be labeled with a pharmacy label.

Additional Corrective Actions The Med Techs will audit Med Carts by 2/27/26, then weekly X 4 weeks, to ensure that all medications are labeled. Audits will be completed by 3/27/26.
RCD is responsible for sustained compliance.

Ongoing Quality Assurance Actions The RCD and Wellness Nurse will review med cart audits each month to ensure that all medications are labeled. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 January, February, and March in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/05/2026)

184b - Labeling OTC/CAM

19. Requirements

184b - Labeling OTC/CAM *(continued)*

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On [redacted], a package of low dose aspirin belonging to resident [redacted] was in the home's SDCU medication cart and was not labeled with the resident's name or correct room number.

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions – The aspirin was immediately removed from the cart on 1/8/26 by the RCD.
The RCD, MCD, Wellness Supervisor and Med Techs were re-educated on 1/21/26 by the Executive Director and the AED on DHS regulations 2600.184b to ensure that OTC and CAM belonging to the residents shall be identified with the resident's name.

Additional Corrective Actions - The Med Tech will audit all Med Carts by 2/27/26, then weekly X 4 weeks, to ensure that OTC and CAM are labeled with the resident's name and room number. Audit will be completed by 3/27/26.
RCD is responsible for sustained compliance.

Ongoing Quality Assurance Actions – The RCD and Wellness Nurse will review med cart audits each week to ensure that all medications are labeled. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/05/2026)

227g -Support Plan Signatures

20. 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.

Repeat Violation: [redacted]

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions – The AED, RCD and MCD were re-educated 2/6/26 by the Executive Director and AED on DHS regulation 2600.227.g to ensure that individuals who participate in the development of the support plan shall sign and date the support plan.

Additional Corrective Actions - The RCD, and MCD will audit all residents support plans by 2/27/26, then MCD and/or RCD will audit support plans weekly X 4 weeks to ensure that they have been signed by the individuals that participate in the development of the plan. Audit will be completed by 3/27/26.
MCD and RCD are responsible for sustained compliance

Ongoing Quality Assurance Actions – The RCD or MCD will review a 5% sample of new resident's support plans each month to ensure that all signatures have been obtained. Ongoing compliance will be reviewed at Quarterly QA

227g Support Plan Signatures (continued)

Meetings with a review of Q1 2026 January, February, and March in April 2026.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Not Implemented [redacted] - 03/05/2026)

227h - Support Plan Refuse Sign

21. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident [redacted] participated in the development of [redacted] support plan on [redacted]. The resident was unable to sign the support plan. The home did not make a notation regarding the resident's inability/refusal to sign.

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions The AED, RCD and MCD were re educated on 2/6/26 by the Executive Director and AED on DHS regulation 2600.227h, to ensure that if a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Additional Corrective Actions The RCD and MCD will audit all residents support plans by 2/27/26, then MCD and/or RCD will audit new support plans weekly X 4 weeks to ensure that support plans have been signed or refusal or inability to sign has been documented. Audits will be completed by 3/27/26.
MCD and RCD are responsible for sustained compliance

Ongoing Quality Assurance Actions The RCD or MCD will review a 5% sample of new resident's support plans each month to ensure that all signatures have been obtained. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 January, February, and March in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/05/2026)

231b - Medical Evaluation

22. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the Secured Dementia Care Unit (SDCU) on [redacted]; however, the resident's medical evaluation was completed on [redacted].

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions The RCD, MCD and Sales Director were re educated 2/9/26 by the Executive Director and AED on DHS regulation 2600.231.b to ensure that prescreen and documentation of medical evaluations are

231b - Medical Evaluation (continued)

completed timely.

Additional Corrective Actions - The RCD and MCD will audit all residents Pre Screens and DME's by 2/27/26 to ensure accuracy and timely completion. Then, MCD and/or RCD will audit new Prescreens and DME's weekly X 4 weeks to ensure timely completion. Audits will be completed by 3/27/26.
MCD and RCD are responsible for sustained compliance

Ongoing Quality Assurance Actions – The RCD or MCD will review a 5% sample of new resident's DME's and Pre-screens each month to ensure that documents are completed timely. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented (03/05/2026)

231c - Preadmission Screening

23. Requirements

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

Description of Violation

Resident was admitted to the SDCU on However, the resident's written cognitive preadmission screening was completed on .

Plan of Correction ***Accept (- 02/18/2026)***

Immediate Corrective Actions – The RCD, MCD were re-educated 2/9/26 by the Executive Director and AED on DHS regulation 2600.231.c to ensure that prescreen is completed within 72 hours of admission to a secured dementia care unit.

Additional Corrective Actions - The RCD, MCD and/or designee will audit all residents Pre Screens by 2/27/26. Then, MCD and/or RCD will audit new Prescreens weekly X 4 weeks to ensure timely completion. Audit will be completed by 3/27/26.
MCD and RCD are responsible for sustained compliance

Ongoing Quality Assurance Actions – The RCD or MCD will review a 5% sample of new resident's prescreens each month to ensure that prescreen is completed within 72 hours of admission to a secured dementia care unit. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented - 03/05/2026)

251c - Standardized Forms

24. Requirements

251c - Standardized Forms *(continued)*

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident [redacted]'s medical evaluation dated [redacted] and resident #[redacted] medical evaluation dated [redacted] were not completed on the Department's standardized Personal Care Document of Medical Evaluation form.

Resident [redacted] medical evaluation dated [redacted] was not completed on the Department's current standardized form. The form was updated to a new format and is required to be used for all medical evaluations completed on or after [redacted]

Plan of Correction ***Accept [redacted] - 02/18/2026)***

Immediate Corrective Actions – Resident #[redacted] and [redacted] Medical evaluations will be completed on DHS standardized forms by 2/27/26.
The RCD, MCD and Sales Director were re-educated 1/21/26 by the Executive Director and AED on DHS regulation 2600.231.b to ensure that the home is using standardized forms to record information on the resident's record.

Additional Corrective Actions - The RCD, MCD and/or designee will audit all residents' Medical Evaluations by 2/27/26. Then, MCD and/or RCD will audit new DME's weekly X 4 weeks to ensure they are completed on the correct standardized forms. Audits will be completed by 3/27/26.
MCD and RCD are responsible for sustained compliance.

Ongoing Quality Assurance Actions – The RCD or MCD will review a 5% sample of new resident's DME's each month to ensure that only standard PC forms are used. Ongoing compliance will be reviewed at Quarterly QA Meetings with a review of Q1 2026 – January, February, and March-in April 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Not Implemented [redacted] - 03/05/2026)