pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **FAWN CARE LLC**
LEGAL ENTITY

To operate **FAWN CARE**
NAME OF FACILITY OR AGENCY

Located at **282 SHAWNDEROSA DRIVE, TARENTUM, PA 15084**
(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 **16**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

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

and shall remain in effect from **January 16, 2026** until **July 16, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454051**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 16, 2026

[redacted]
Fawn Care LLC
282 Shawnderosa Drive
Tarentum, Pennsylvania 15084

RE: Fawn Care
License #: 454051

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on August 26, 2025, August 28, 2025, October 22, 2025, and November 6, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 454050) dated July 11, 2025 – July 11, 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) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from JANUARY 16, 2026 to JULY 16, 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.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

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

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: *FAWN CARE* **License #:** *45405* **License Expiration:** *07/11/2026*

Address: *282 SHAWNDEROSA DRIVE, TARENTUM, PA 15084*

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

Administrator

Name: [redacted]

Legal Entity

Name: *FAWN CARE LLC*

Address: *282 SHAWNDEROSA DRIVE, TARENTUM, PA, 15084*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *R-4* **Date:** *05/11/2017* **Issued By:** *Middlesex Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *17* **Waking Staff:** *13*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date:** *08/28/2025*

Inspection Dates and Department Representative

08/26/2025 - On-Site: [redacted]

08/28/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* **Residents Served:** *14*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older:** *14*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *1*

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

Inspections / Reviews

08/26/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/13/2025*

09/12/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/01/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/18/2025*

09/19/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/01/2025*

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

12/09/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/01/2025*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted on 9/23/16, requires the date of battery installation to be present on the battery of all battery-operated carbon monoxide detectors. However, on 8/26/25, the date of battery installation was not present on the battery-operated carbon monoxide detector, located in the home's kitchen.

Plan of Correction ***Accept [redacted] - 09/12/2025)***

- The carbon monoxide detector was immediately taken down, had a new battery installed, as well as a label properly documenting the date of battery installation.
- An audit was conducted on 8/27/2025 by owner, [redacted] to ensure that all carbon monoxide detectors were properly labeled with no additional findings.
- Current staff will be educated by owner on Regulation 18, applicable health and safety laws, The Care Facility Carbon Monoxide Alarms Standards Act, which requires the date of battery installation to be present on the battery of all battery-operated carbon monoxide detectors by 9/20/2025.
- The monthly maintenance checklist has been updated to review carbon monoxide battery labels monthly to ensure they continue to be properly labeled and in complianc

Licensee's Proposed Overall Completion Date: *09/30/2025*

Not Implemented [redacted] - 12/09/2025)

65i - Training Record

2. Requirements

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

Description of Violation

The record of training for fire safety training, dated 2/19/24, does not include the source or length of the training. Numerous staff persons received this training, including staff persons A and B.

REPEAT VIOLATION: 9/20/2024, et. al.

Plan of Correction ***Accept [redacted] - 09/19/2025)***

- Owner provided verbal education to all staff members on 9/1/2025 regarding regulation 65.i.
- Owner updated the training requirement audit sheets to include the staff person trained, date, source, content, length of each course and copies of any certificates received and the location they shall be kept.
- Current staff will be educated by owner on or before 9/302025 on regulation 65.i.

An audit will be completed each month beginning October 1 to ensure that training records are completed

65i - Training Record (continued)

correctly which includes staff person trained, date, source, content, length of each course ad copies of certificate received. The administrative assistant will be responsible to complete audits.

Licensee's Proposed Overall Completion Date: *10/01/2025*

Not Implemented (- 12/09/2025)

121a - Unobstructed Egress

3. 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 8/26/25 at 10:25am, a large toy train was present directly outside the exit door from the kitchen to the outdoor patio, blocking this egress route.

Plan of Correction ***Accept - 09/19/2025)***

- On 8/26/2025, the removed the train from outside of the exit door of the kitchen.
- An audit was conducted on 8/27/2025 by the owner to ensure regulation 121.a is being met, with no additional findings.
- All staff will be educated by owner on regulation 121.a by 9/30/2025.
- A daily audit egress audit has been implemented to ensure that all egress routes are unobstructed at the beginning and end of each shift. These audits will be reviewed at quarterly QI meetings.
- The audits will begin on October 1, 2025, and will be completed by the administrative
- Each shift will be responsible to walk through the home and ensure hallways, doorways, and egress routes from rooms are unobstructed, along with documenting the results. The owner will review the outcome of these audits and present them at the next quality management review meeting which is scheduled for October 1, 2025. Any concerns will be addressed at this time and will be corrected. All staff education is kept in a 2025 training binder.

Proposed Overall Completion Date: 10/01/2025

Licensee's Proposed Overall Completion Date: *10/01/2025*

Not Implemented - 12/09/2025)

132e - Fire Drill Sleeping Hours

4. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

According to the home's fire drill records, the only fire drill held during sleeping hours between 9/24/24-8/26/25 was

132e - Fire Drill Sleeping Hours (continued)

conducted on 8/21/25 at 5:00am.

Plan of Correction ***Directed (- 09/19/2025)***

- On 8/30/2025 a fire drill was held during sleeping hours and will be held quarterly from this point on to ensure compliance with regulation 132.e.
- Current staff will be educated on 132.e by owner by 9/30/2025. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 9/19/25).
- The monthly fire drill compliance audit has been updated to include regulation 132.e (DIRECTED: Beginning on 10/1/25: The administrator shall review all fire drill documentation monthly to ensure compliance with 2600.132e. 9/19/25).

On 9/17/2025 staff were re-educated on evacuation procedures, staff duties and responsibilities, and designated meeting place. Staff that were not able to attend will meet with the owner 1:1 regarding the training. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. LM 9/19/25).

Proposed Overall Completion Date: 09/17/2025

Directed Completion Date: *10/01/2025*

Not Implemented - 12/09/2025)

183b - Meds and Syringes Locked

5. 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 8/26/25 at 10:43am, a Lantus Solostar-100u/ml insulin pen and an Aspart-100u/ml insulin kwikpen belonging to resident #1 were unlocked, unattended, and accessible on a table in the home's dining room.

Plan of Correction ***Directed - 09/19/2025)***

- The unlocked items were immediately relocated to the locked medication cart.

- An audit was conducted o 8/27/2025 by owner to ensure that regulation 183.b is being met, with no further findings.
- Current staff will be educated by owner on regulation 183.b, prescription medications, OTC medications, CAM ad syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the residents room by 9/20/2025/ (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 9/19/25).
- The daily medication policy regarding locked containers including medications and syringes will be implemented

183b - Meds and Syringes Locked (continued)

with daily checks of all medications.

Each med tech will be responsible for the daily checks when they receive the med keys. On September 5, 2025 med techs were re-educated to ensure compliance with 2600.183 b, by the owner.

Proposed Overall Completion Date: 09/20/2025

Directed Completion Date: *09/20/2025*

Not Implemented [redacted] - 12/09/2025)

183c - Refrigerated Meds Locked

6. Requirements

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

On 8/26/25 at approximately 10:30am, 2 boxes of resident #2's Ozempic-8mg/3ml pens were unlocked and accessible in the kitchen refrigerator next to the stove. Additionally, there were 2 boxes Lantus Solostar-100unit/ml insulin pens unlocked and unattended in this refrigerator. The 2 boxes of Lantus insulin pens included pharmacy labels; however, the names were blackened out with a permanent marker and were unable to be read.

Plan of Correction ***Directed ([redacted] - 09/19/2025)***

- Owner immediately put the Ozempic syringe in a secured locked box, which is kept in the refrigerator. The unmarked insulin was immediately discarded,
- An audit was conducted by the owner o 9/1/2025 to ensure the regulation 183.c is being followed with no additional findings.
- Current staff will be educated by on 183.c, prescription medications, OTC medications and CAM, stored in a refrigerator shall be kept in an area or container that is locked by 9/30/2025. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/19/25).

Staff were re-educated o 183.c on September 5, 2025 by owner. A weekly audit will be completed by the administrative assistant to ensure compliance of all medications. (DIRECTED: The weekly audits shall begin on 9/22/25 and shall include an audit of all refrigerators where medications are stored to ensure compliance with 2600.183c. [redacted] 9/19/25).

Proposed Overall Completion Date: 09/20/2025

Directed Completion Date: *09/22/2025*

Not Implemented [redacted] - 12/09/2025)

184a - Resident's Meds Labeled

7. 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

On 8/26/25 at approximately 10:30am, there were 2 boxes Lantus Solostar-100unit/ml insulin pens present in the kitchen refrigerator next to the stove which included pharmacy labels; however, the names were blackened out with a permanent marker and were unable to be read.

On 8/26/25 at 10:43am, no pharmacy label was present on resident #1's Lantus Solostar-100u/ml insulin pen, which was unattended on a table in the home's dining room.

Plan of Correction ***Directed [redacted] - 09/19/2025)***

- The owner immediately discarded the blackened out label of the lantus boxes,
- the lantus without a label was immediately places in a bag with the proper label.
- An audit was conducted by the owner o 9/1/2025 to ensure regulation 184.a, the original container on prescription medications shall be labeled with a pharmacy label that includes the following: residents name, medication name, date prescription was issued, prescribed dosage and administration instructions, name and title of prescriber with no additional findings.
- Current staff will be educated by owner on regulation 184.a, the original container for prescription medications shall be labeled with a pharmacy label including all mandated information by 9/30/2025. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/19/25).
- There will be a monthly audit implemented ensuring that all medications are labeled properly and have all required information to comply with regulation 184.a which will be reviewed at quarterly QI meetings. (DIRECTED: Beginning on 9/22/25: The administrator shall review all medications and the pharmacy labels for at least 6 different residents per month to ensure compliance with 2600.184a. [redacted] 9/19/25).

Proposed Overall Completion Date: 09/30/2025

Directed Completion Date: *09/30/2025*

Not Implemented [redacted] - 12/09/2025)

185a - Implement Storage Procedures

8. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

18 [redacted]

- Physician will write order for any appropriate resident to independently monitor blood glucose levels, and self administer sliding scale insulin doses, along with completion of the DHS self administer test and will be kept in residents charts.
- Owner provided verbal education to staff members A and B in person on 8/27/2025 regarding the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persona.
- Owner will update any and all residents orders to allow self administration for appropriate residents, which will include the DHS self administration test. The order update will be completed by 9/30/2025.
- Owner will provide all current staff education which includes procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons by 9/30/2025, and keep documentation of this in training audit file.
- Owner will audit 25% of resident orders once a month to ensure compliance with regulation 185.a and document findings actions taken. and compliance checks and will review at quarterly QI meetings.

Resident #1 has been completing [redacted] own blood sugar glucose, however after [redacted] completes the testing, staff gather up [redacted] equipment and lock it up in the med cart. At the time of licensing, staff did not gather [redacted] glucometer nor [redacted] insulin to lock it back up. At the current time, there are three(3) residents that require blood sugar testing. At the current time, no resident has been assessed by a physician to acknowledge if they are able to complete their blood sugar testing independently. On the next home visit by the physician, they will be assessed. (DIRECTED: Documentation shall be kept from the physician for any resident who is assessed to self-check their blood sugars. [redacted] 9/19/25).
The administrator will complete daily audits of the MARS for two weeks, then monthly thereafter to ensure complete blood sugar documentation is present, as well as ensuring all medications that were administered to residents are documented on the MAR. All audits will be kept. (DIRECTED: The daily audits shall begin on 9/22/25 and include a review of all resident MAR's during each audit to ensure accurate and complete blood sugar documentation is

185a - Implement Storage Procedures (continued)

present and to ensure all resident MAR's are initialed by staff persons at the time of medication administration in accordance with 2600.187b. Documentation of the daily audits shall be kept. [redacted] 9/19/25).

Proposed Overall Completion Date: 09/30/2025

Directed Completion Date: *09/30/2025*

Not Implemented ([redacted] - 12/09/2025)

187a - Medication Record

9. Requirements

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

On 8/26/25, there was no August 2025 medication administration record (MAR) present in the home for resident #1. Resident #1 is prescribed numerous medications, including Lantus Solostar-100u/ml insulin pen.

Numerous medications currently prescribed to resident #3 were not included on resident #3's August 2025 MAR, to include the following:

- *Gabapentin 300mg capsule-Take 1 capsule by mouth 4 times daily*
- *Meclizine 12.5mg tablet-Take 1 tablet by mouth 3 times daily*
- *Pantoprazole 40mg tablet-Take 1 tablet by mouth once daily*

Resident #3 is currently prescribed Fluoxetine 20mg tablet-Take 1 tablet by mouth every day at 9:00am; however, this medication is listed twice on resident #3's August 2025 MAR. Also, resident #3's August 2025 MAR does not include the route of administration for this medication, which is orally.

Resident #4 is currently prescribed Metoprolol XR 25mg tablet-Take 1 tablet by mouth every day at 9:00am; however, this medication is not included on resident #4's August 2025 MAR.

Resident #5 is currently prescribed Metoprolol Tartrate 25mg tablet-Take 1/2 tablet by mouth 2 times daily; however,

187a - Medication Record (continued)

this medication is not included on resident #5's August 2025 MAR.

REPEAT VIOLATION: 9/20/2024, et. al.

Plan of Correction ***Directed [redacted] - 09/19/2025)***

- Owner provided verbal education to all staff who are med techs in person on 8/27/2025 regarding regulation 187.a, a medication record shall be kept to include required information for each resident for whom medications are administered.
- Owner updated MARS to ensure accuracy, correct information including name, drug allergies, name of medication, strength, dosage form, dose, route of administration, administration times, duration of therapy, special precautions, diagnosis or purpose of the medication, including PRN, date ad time of medication administration ad name and initials of staff person administering the medication on 8/27/2025.
-On 9/1/2025 owner implemented use of electronic MARSs via Tabula Pro, and also applied for a waiver to utilize the platform. This includes monitoring of all MARS by the pharmacist and long term care pharmacy specialists, the Tabula Pro specialist who ensures compliance as well as the facilities med techs and owner.
- Owner will provide all current staff who are med techs educations which includes regulations 187.a in their entirity are implemented as well as the corrective actions which need taken upon discovery of an error. This training as well as documentation including all required training information and will be completed by 9/30/2025.
- Owner will audit 25% of the MARS on a monthly basis to ensure compliance for regulation 187.a regarding elements of a MAR documentation of audit will be kept in a audit binder and will be discussed at quarterly QI meetings

Since date of licensing, the home has began electronic MARS. Monthly audits will begin on October 1, 2025, at which time 50% of the MARS will be audited by the owner. The next quarterly quality meeting is on October 1, 2025, which all concerns regarding MARS will be addressed and audits will be reviewed. all results of the quality management review are kept in a binder.

Proposed Overall Completion Date: 09/17/2025

Directed Completion Date: *09/30/2025*

Not Implemented [redacted] - 12/09/2025)

187b - Date/Time of Medication Admin.

10. Requirements

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

Description of Violation

On 8/26/25, an agent of the Department requested the August 2025 MAR's for residents #3, #4 and #5 from staff person C. The provided MAR's indicate staff persons A, B or C administered the prescribed medications to residents #3, #4 and #5 on a daily basis from 8/1/25 through 8/26/25. However, later in the day it was discovered that staff

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

persons A, B, and C did not initial residents #3, #4 and #5 August 2025 MAR's at the time of medication administration, and that on the morning of 8/26/25, staff persons A, B and C added their initials to resident #3, #4 and #5's August 2025 MAR's indicating all medications were administered to the residents daily from 8/1/25 through 8/26/25. Staff persons A and B indicated they did not document daily medication administration on resident #3, #4 and #5's August 2025 MAR's from 8/1/25 through 8/26/25 at the time of medication administration. Additionally, staff persons A and B indicated they have not documented any medication administration on any resident MAR for the month of August, 2025.

REPEAT VIOLATION: 3/26/2025

Plan of Correction ***Directed [redacted] - 09/19/2025)***

- Owner immediately collaborated with [redacted], administrative assistant, ad shift supervisor went in person to [redacted] Pharmacy and worked with both pharmacists to ensure that MARS were properly entered into the system and had all DHS required information for each resident. This began on 8/26/2025 and carried over to 8/27/2025, and as of 8/28/2025, all MAR records were complete, correct, and actively utilized on all shifts, as well as being signed for in a timely manner. Owner also educated staff members A and B on the importance of proper documentation, implementation of regulation 187.b, and the procedure in effect in case of error or if a discrepancy arises on 8/27/2025.

- Owner updated house policies to include the proper techniques and requirements for proper medication administration and documentation. Owner also educated staff A and B on the prohibition on not signing MARS at the time of medication administration. Pharmacy has also participated for training which teaches the DHS requirements for required information on MARS and the importance of signing at the time of administration and the absolute necessity of the facility having correct and true MARS that include all department required information as well as the policies that are in place when a discrepancy arises. This will be completed and in effect by 9/30/2025. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/19/25).

- Owner and administrative assistant will provide all current med techs education which includes that each resident will have their MARS current, accurate to include all information to satisfy regulation 187.b, in regards to proper recording at the time of administration by a med tech. Details of newly added task prompts required at the time of medication administration. This education will be completed by 9/30/2025. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 9/19/25).

- Owner will audit med techs randomly throughout the month to ensure that proper signing for medication administration is taking place at all times and will document these random checks, as well as any corrective actions on a specifically designed sheet, which includes the date, time and findings of the check along with any corrective actions taken, additional trainings, and monitoring needed, which will be kept in the audit binder and the finding will be discussed at the quarterly QI meeting. These random checks will begin on 9/1/2025 and coinciding at random times, along with coinciding documentation, moving forward. (DIRECTED: The observation of med tech medication administrations shall include an observation by the administrator for each med tech at least monthly. Documentation of the observations shall be kept for 2 months. [redacted] 9/19/25).

The home recently switched to a new pharmacy which had minimal experience with long term facilities. Fawn Personal Care along with the pharmacy have been working together to get physician orders and the MARS correct. Recently the home has switched to an electronic MARS which now can also be monitored by the pharmacy,
The administrator will audit all residents MARS daily for 2 weeks, then monthly thereafter to ensure all medications that were administered to residents are documented on the MAR. All documentation will be kept in a binder. (DIRECTED: The daily audits shall begin on 9/22/25 and include a review of all resident MAR's during each

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

audit to ensure all resident MAR's are initialed by staff persons at the time of medication administration in accordance with 2600.187b. Documentation of the daily audits shall be kept. [redacted] 9/19/25).

Since licensing, the home along with the pharmacy are now using an electronic system for medications and MARS.

Proposed Overall Completion Date: 09/30/2025

Directed Completion Date: *09/30/2025*

Not Implemented [redacted] - 12/09/2025)

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

Facility Information

Name: *FAWN CARE* **License #:** *45405* **License Expiration:** *07/11/2026*

Address: *282 SHAWNDEROSA DRIVE, TARENTUM, PA 15084*

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

Administrator

Name: [redacted]

Legal Entity

Name: *FAWN CARE LLC*

Address: *282 SHAWNDEROSA DRIVE, TARENTUM, PA, 15084*

Phone: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *17* **Waking Staff:** *13*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *10/22/2025*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* **Residents Served:** *14*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older:** *13*

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

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

Inspections / Reviews

10/22/2025 - Partial

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

Inspections / Reviews *(continued)*

11/12/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/04/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/18/2025*

11/19/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/04/2025*

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

12/09/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/04/2025*

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

162a - Hours Between Meals

2. Requirements

2600.
162.a. There may not be more than 15 hours between the evening meal and the first meal of the next day. There may not be more than 6 hours between breakfast and lunch, and between lunch and supper. This requirement does not apply if a resident's physician has prescribed otherwise.

Description of Violation

On the day of inspection, residents were not served breakfast until approximately 11:00am; however, the dinner meal on the previous day was served at approximately 5:30pm.

Plan of Correction ***Directed [redacted] - 11/18/2025)***

Staff involved were immediately re-educated on 10/22/2025 regarding mealtime requirements, The meal schedule was immediately adjusted to ensure compliance.
All direct care staff have been re-trained on 55Pa. Code 2600.162a, emphasizing that no more than 15 hours may pass between the evening meal and the next day's first meal, The posted meal schedule has been reviewed and confirmed for compliance. The Administrator will review meal service logs daily for 30 days, then weekly thereafter, to audit for compliance with time frames. (DIRECTED: The daily reviews shall begin on 11/24/25. [redacted] 11/18/25).

EDIT: Fawn respectfully contests this citation. On the day of inspection, residents had already been served breakfast in the living quarters prior to the inspectors' arrival. After finishing breakfast, residents chose to move to the dining room to enjoy fruit and coffee, as they are permitted to utilize any common area of the facility per their choice and comfort. This created the appearance that breakfast service was delayed. To ensure clarity moving forward, breakfast is now scheduled for 9am daily, lunch at 2pm, dinner at 7pm, with snacks offered mid day and evening to ensure all nutritional and timing requirements are fully met. (DIRECTED: Beginning on 11/24/25: The administrator/designee shall observe each meal at least once weekly to ensure compliance with 2600.162a. [redacted] 11/18/25). The Admin. Ass. and dietary staff will continue to monitor all meal and snack schedules to maintain compliance and resident satisfaction. All staff were educated 11-10-2025. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 11/18/25). Reviewing meal service logs will ensure timely service of meals by ensuring constant compliance wit hdesignated meal times, and if something is off track, it will immediately be able to be addressed.

Proposed Overall Completion Date: 11/25/2025

Directed Completion Date: *11/25/2025*

Implemented ([redacted] - 12/09/2025)

183a - Original Containers and Injections

3. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

At approximately 11:30am, there were 7 loose pills at the bottom of Resident #1's plastic bin, which contained

183a - Original Containers and Injections (continued)

resident #1's medications.

Plan of Correction ***Accept [redacted] - 11/18/2025)***

The 7 loose pills were immediately removed from Resident#1 bin and discarded per facility policy on 10/22/2025.
Resident #1's bin was audited to ensure all other medications were in the original labeled containers.
All medication certified staff will be re-trained on 2600.183.a, stressing that medications must not be removed from original containers more than 2 hours before administration. The Administrator or designee will conduct random weekly audits of medication bins to ensure no loose pill are present.

EDIT: The education was completed 11-10-2025, and will be kept in the training binder. Weekly audits begin on 11-10-2025 and will actually be completed 3 unannounced times per week, which means that 3 residents medications will be audited per week.

Licensee's Proposed Overall Completion Date: *11/25/2025*

Not Implemented [redacted] - 12/09/2025)

183b - Meds and Syringes Locked

4. Requirements

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

Description of Violation

At 9:34am, numerous medication blister packs were unlocked, unattended and accessible in the home's office/laundry room, to include the following medications:

- *Resident #2's Trazadone-50mg tablets*
- *Resident #3's Eliquis-5mg tablets and Benzonatate-100mg capsules*
- *Resident #4's Tramadol HCL-50mg tablets, Furosemide-40mg tablets and Levofloxacin-250mg tablets*

Plan of Correction ***Directed ([redacted] - 11/18/2025)***

All medication cited were immediately secured in a locked area by staff on 10/22/2025.
All staff have been re-trained on 2600.183.b., stating all medication must be kept locked. The office/laundry room door will be kept locked at all times when staff are not present. The Administrator will conduct daily, random checks of all medication storage areas for 30 days to ensure 100% compliance. (DIRECTED: Immediately following the daily audits, the administrator/designee shall audit all medication storage areas weekly to ensure compliance with 2600.183b.[redacted] 11/18/25).

EDIT: The education was completed 11-10-2025 and will be kept in the training binder. Daily audits began on 11-10-2025.

Proposed Overall Completion Date: 12/11/2025

Directed Completion Date: *11/25/2025*

Not Implemented [redacted] - 12/09/2025)

183c - Refrigerated Meds Locked

5. Requirements

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

At 9:03am, there were 2 boxes of resident #5's Risperidone extended release 25mg/vials unlocked, unattended and accessible in the kitchen refrigerator.

Plan of Correction ***Directed (- 11/18/2025)***

The medication for Resident #5 was immediately placed in a locked container with the refrigerator on 10/22/2025, All staff have been re-trained on 2600.183.c., requiring refrigerated medications to be locked. All refrigerated medications in the home have been audited and secured in locked containers, The refrigerator check is now part of the Administrator's daily medication storage audit.

EDIT: The education was completed 11-10-2025 and will be kept in the training binder. The daily audits began 11-10-2025.

Proposed Overall Completion Date: 12/11/2025

Directed Completion Date: *11/25/2025*

Not Implemented - 12/09/2025)

183e - Storing Medications

6. 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

Resident #6's Lantus Solostar insulin pen was open and undated in the diabetes care lockbox. According to the manufacturer's instructions, Lantus insulin must be used within 28 days of opening.

Resident #6's Aspart insulin pen was open and undated in the diabetes care lockbox. According to the manufacturer's instructions, Aspart insulin must be used within 28 days of opening.

Plan of Correction ***Directed - 11/18/2025)***

Both updated insulin pens were immediately discarded on 10/22/2025. New pens were obtained and the "Date Opened" and "Discard Date" (28 days from opening) were written.
All medication-certified staff will be re-trained p 2600.183.e., with specific focus on dating multi-dose medications (insulin, inhalers, eye drops) upon opening, per manufacturer's instructions. The Administrator or designee will conduct weekly audits of the diabetes care lockbox and all other medication storage to ensure all multi-dose items are properly dated .

183e - Storing Medications (continued)

EDIT: The education was completed on 11-10-2025 and documentation of the education will be kept in the training binder. Weekly and daily audits begin on 11-10-2025.

Proposed Overall Completion Date: 12/11/2025

Directed Completion Date: *11/25/2025*

Not Implemented [redacted] - 12/09/2025)

184a - Resident's Meds Labeled

7. 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

Resident #6 is currently prescribed Lantus Solostar insulin pen-Inject 28 units subcutaneously nightly; however, resident #6's pharmacy label indicates Lantus Solostar insulin pen-Inject 25 units subcutaneously nightly.

There is no pharmacy label present on resident #6's Lantus Solostar insulin pen, which was stored in the diabetes care lockbox.

Plan of Correction ***Directed [redacted] - 11/18/2025)***

The pharmacy was immediately contacted on 10/22/2025 to correct the label for the 28 unit prescription. The unlabeled pen (also cited in violation #6) was discarded and replaced with a new, correctly labeled pen.
All medication staff will be re-trained on 2600.184.a. A new policy will be implemented requiring staff to verify all pharmacy labels against the MAR and prescriber's order when medications are delivered from the pharmacy, before they are stored, (DIRECTED: By 11/25/25: The administrator shall re-educate all staff persons qualified to administer medications on the home's new policy, as well as 2600.184a. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 11/18/25). Any discrepancies will be resolved with the pharmacy before administration.

The pharmacy corrected the violation to resident #6's incorrect pharmacy label and the corrective action that was completed was immediately discarding the undated insulin pens on 10-22-2025. New pens were obtained and the "Date Opened" and "Discard Date" (28 days from opening) were written on each.. The designee will conduct weekly audits of the diabetes care lockbox and all other medication storage to ensure multi-dose items are properly dated and will immediately address any and all discrepancies immediately.

184a - Resident's Meds Labeled (continued)

DIRECTED: Beginning on 11/24/25: The administrator/designee shall review the medications for at least 3 different residents weekly for 1 month then monthly thereafter to ensure accurate and complete pharmacy labels are present in accordance with 2600.184a. [redacted] 11/18/25).

Proposed Overall Completion Date: 12/11/2025

Directed Completion Date: *11/25/2025*

Not Implemented [redacted] - 12/09/2025)

185a - Implement Storage Procedures

8. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #6's glucometer is not set to the current time.

The home's medication policies and procedures indicate controlled substances are to be counted at the change of each shift and each staff member is to sign the log after the count to verify the count; however, according to staff person A, staff persons are not currently counting controlled substances at the change of each shift.

The home's medication policies and procedures indicate staff persons are to document the administration of controlled substances on the resident's MAR, as well as on the controlled count sheet; however, at the time of inspection, no controlled count sheets were present for numerous residents prescribed a controlled substance, to include the following:

- *Resident #7's Fentanyl 25mcg/hour-Apply 1 patch topically and change every 72 hours*

Plan of Correction ***Directed [redacted] - 11/18/2025)***

1) Resident #6 glucometer time was corrected on 10/22/2025.
2) Controlled substance counts at each shift change were immediately re-instated on 10/22/2025.
3) Controlled substance counts sheets were immediately created and put into use for Resident #7 and all other residents prescribed controlled substances.
All staff have been re-trained on the home's medication policies and procedures 2600.185.a, This training emphasized the mandatory procedure for shift-to-shift counts and correct documentation on count sheets, The Administrator will review the controlled substance count sheet daily for 30 days (then weekly) to ensure 100% compliance. All medical equipment (glucometers, etc.) will be checked weekly for proper function and settings.

EDIT- Weekly glucometer checks began on November 10, 2025. (DIRECTED: All resident glucometers shall be checked weekly by the administrator/designee to ensure they are set to the current date and time. [redacted] 11/18/25). There was an oversight by the home in regards to this policy, which will be remedied with the additional means of oversight and verification moving forward. Teh education was completed on 11-10-2025 and will be kept in the training binder. The education included re-education on the home's policy for staff persons to sign off on the controlled substance counts daily . Weekly reviews of the counts begin on 11-10-2025 and do include a weekly

185a - Implement Storage Procedures (continued)

review of all resident count sheets who are prescribed a controlled substance. the weekly reviews will also include ensuring staff persons are signing the logs at the end of each shift in accordance with the homes policy. (DIRECTED: The weekly reviews shall also include a review of each resident's MAR, controlled count sheets and a physical count of each controlled substance for all residents prescribed a controlled substance to ensure accuracy and completeness. Documentation of the weekly audits shall be kept for 1 month. [redacted] 11/18/25).

Proposed Overall Completion Date: 12/11/2025

Directed Completion Date: *12/01/2025*

Not Implemented ([redacted] - 12/09/2025)

187a - Medication Record

9. Requirements

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #8 is prescribed Levetiracetam 1,000mg tablet-Take 1 tablet by mouth daily at 9:00am and 9:00pm; however, resident #8's October 2025 medication administration record (MAR) indicates "Levetiracetam 100mg 1,000mg-Take 1 tablet by mouth at 9am and 9pm".

Resident #8 is prescribed Oxycodone 5mg tablet-Take 1 tablet by mouth every 8 hours as needed; however, resident #8's October 2025 MAR does not include the strength of this medication.

Resident #9 is prescribed Probiotic 500m cfu capsule-Take 1 capsule by mouth daily at 9:00am and 9:00pm; however, this medication is not indicated on resident #9's October 2025 MAR.

Resident #10 is prescribed ABHR Gel 1/25/1/10-Take 1ml by mouth every 6 hours as needed; however, resident #10's October 2025 MAR does not include the frequency of this medication administration.

Resident #10 is prescribed Furosemide 20mg tablet-Take 1 tablet by mouth daily as needed; however, resident #10's

187a - Medication Record (continued)

October 2025 MAR does not include the frequency of this medication administration.

Resident #10 is prescribed Escitalopram 20mg tablet-Take 1 tablet by mouth daily at 9:00am; however, resident #10's October 2025 MAR indicates "Escitalopram 20mg 10mg-1 tablet at 9:00am"

REPEAT VIOLATION: 9/20/2024, et. al.

Plan of Correction ***Directed ([redacted] - 11/18/2025)***

All MARS for Residents #8, #9, and #10 were immediately audited and corrected by the Administrator on 10/22/2025 to match current prescribers orders.
As this is a repeat violation, a robust plan is being implemented.
1) The Administrator will conduct a 100% audit of all current resident MARs against prescribers orders by 11/8/2025..a.
2) All medication certified staff will undergo mandatory re-training on 2600.187.a
3) A new "MAR Verification" policy is effective immediately. The Administrator must review and sign off on 100% of all new monthly MARs before the first of the month to ensure accuracy.
4) The Administrator will conduct weekly random audits of 5 resident MARs to ensure no errors arise mid-month.

2) All medication certified staff will undergo mandatory re-training on 2600.187

EDIT: The education was completed 11-10-2025 and documentation will be kept in the training binder. steps 3 and 4 begin on 11-10-2025.

Proposed Overall Completion Date: 12/11/2025

Directed Completion Date: *12/01/2025*

Not Implemented [redacted] - 12/09/2025)

187b - Date/Time of Medication Admin.

10. Requirements

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

Description of Violation

Resident #7 is prescribed Fentanyl 25mcg/hour patch-Apply 1 patch topically and change every 72 hours; however, this medication was only documented as administered on resident #7's October 2025 MAR on 10/2/25.

Resident #7's October 2025 MAR does not include the initials of the staff person who administered numerous medications to resident #7 on 10/15/25 and 10/20/25 at 9:00pm, to include the following:

- *Bupropion HCL-150mg tablet*
- *Gabapentin-300mg capsule*
- *Quetiapine-25mg tablet*

Resident #8's October 2025 MAR does not include the initials of the staff person who administered the following medications to resident #8 on 10/21/25 at 9:00pm:

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

- *Levetiracetam-1,000mg tablet*
- *Metoprolol Tartrate-25mg tablet*
- *Risperidone-0.5mg tablet*

REPEAT VIOLATION: 3/26/2025

Plan of Correction ***Directed [redacted] - 11/18/2025)***

The MARs for Residents #7 and #8 were reviewed on 10/22/2025, Staff responsible for the omissions were identified and received immediate counseling on the requirement to initial at the time of administration.
As this is a repeat violation:
1) All medication-certified staff will be re-trained on 2600.187.b., emphasizing that documentation is mandatory at the time the medication is administered.
2) The Administrator or designee will conduct daily audits of all MARs from the previous 24 hours to check for 100% completion of initials. Any missed initials will result in immediate re-training for the staff member. This daily audit will continue for 30 days then move weekly,

EDIT: Staff was counseled on 10-23-2025, and education was completed 11-10-2025 (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 11/18/25) and the audits in step 2 begin 11-10-2025.

Proposed Overall Completion Date: 12/11/2025

Directed Completion Date: *12/01/2025*

Not Implemented [redacted] - 12/09/2025)

254c - Records Storing

11. Requirements

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

Description of Violation

At 9:34am, numerous resident records were unlocked, unattended and accessible in the home's laundry room/office, to include medical evaluations and support plans for residents #6 and #10.

At 9:55am, numerous resident records were unlocked, unattended and accessible on a desk in the home's living room, to include face sheets for resident #3, a fax cover sheet regarding medication changes for resident #5 and Urology clinic notes for resident #9.

Plan of Correction ***Directed [redacted] - 11/18/2025)***

All residents records cited were immediately gathered and secured in a locked office/container by staff on 10/22/2025.

254c - Records Storing (continued)

All staff will be re-trained on 2600.254.c. and facility confidentiality/HIPPA policies. Staff are prohibited from leaving any resident records in common area or unlocked. The desk in the living room will no longer be used for any resident-related paperwork. The Administrator will conduct daily walk throughs of all common areas and office spaces for 30 days to ensure no records are left unsecured.

EDIT: Education was completed 11-10-2025 and documentation will be kept in the training binder. daily walkthroughs begin 11-10-2025.

Proposed Overall Completion Date: 12/11/2025

Directed Completion Date: *12/01/2025*

Implemented ([redacted] - 12/09/2025)

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

Facility Information

Name: *FAWN CARE* **License #:** *45405* **License Expiration:** *07/11/2026*

Address: *282 SHAWNDEROSA DRIVE, TARENTUM, PA 15084*

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

Administrator

Name: [redacted]

Legal Entity

Name: *FAWN CARE LLC*

Address: *282 SHAWNDEROSA DRIVE, TARENTUM, PA, 15084*

Phone: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *15* **Waking Staff:** *11*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *11/06/2025*

Inspection Dates and Department Representative

11/06/2025 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* **Residents Served:** *14*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older:** *13*

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

Have Mobility Need: *1* **Have Physical Disability:** *0*

Inspections / Reviews

11/06/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/17/2025*

Inspections / Reviews *(continued)*

11/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/09/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/24/2025*

11/25/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/09/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/08/2025*

12/09/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/09/2025*

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

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

At 9:10am, no cover was present on the bedside mobility device present on the right side of resident #1's bed, which had an opening measuring approximately 12" x 6", which poses an entrapment hazard.

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

IMMEDIATE CORRECTIVE ACTION: The non-compliant bedside mobility device was immediately covered with a snug, form fitting, department compliant cover.
IDENTIFICATION OF OTHERS: The Admin. Ass. conducted a full-house audit on 11-8-2025 to inspect all other resident-owned and facility-owned mobility devices (including wheelchairs, walkers and bedside assists) for safety, good repair, and potential hazards. No other deficient equipment was identified.
SYSTEMIC CHANGE: All direct care staff will receive a mandatory in-service by 11-25-2025 on "Resident Equipment Safety." (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 11/25/25). This training will cover:
-How to identify potential hazards (missing parts, entrapment risks, broken pieces).
-The formal procedure for immediately reporting deficient equipment to the admin. Ass. for repair or replacement.
MONITORING AND QUALITY ASSURANCE: "Equipment Safety Check" will be permanently added to the Admin. Ass. daily walk-through checklist. Furthermore, all Personal Care Aides will be responsible for visually inspecting resident equipment during morning care and reporting any issues.

THE DAILY WALKTHROUGHS BEGIN ON 11-18-2025 AND THE ONLY DOCUMENTATION WILL BE IF THERE IS A PROBLEM, AND THEN A CORRECTIVE ACTION FORM WILL BE FILLED OUT, ADDRESSED AND REMEDIED.

Proposed Overall Completion Date: 11/25/2025

Directed Completion Date: *11/25/2025*

Not Implemented [redacted] - 12/09/2025)

101c - Bedroom Mobility Needs

2. Requirements

2600.
101.c. Each bedroom for one or more residents with a mobility need must have at least 100 square feet per resident, to allow for easy passage between beds and other furniture, and for comfortable use of a resident's assistive devices, including wheelchairs, walkers, special furniture or oxygen equipment. This requirement does not apply if there is a medical order from the attending physician that states the resident can maneuver without the necessity of the additional space. A legal entity with a personal care home license for the home as of October 24, 2005, that has one or more bedrooms serving a resident with physical mobility needs as of October 24, 2005, shall be exempt from the requirements specified in this subsection for the bedroom. If a bedroom is exempt in accordance with this subsection, additional square footage may be required sufficient to accommodate the assistive devices of the resident with mobility needs.

Description of Violation

Bedroom #7 is occupied by 1 resident with mobility needs and 1 resident without mobility needs, requiring a

101c - Bedroom Mobility Needs (continued)

minimum total of 160 square feet; however, bedroom #7 only measures 120.37 square feet.

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

IMMEDIATE CORRECTIVE ACTION AND JUSTIFICATION: A licensed nurse practitioner drafted a formal statement on 11-11-2025 verifying that, as per regulations, the amount of room required is not necessary for the movement and safety of the resident with mobility needs in Room #7. This physician's statement is maintained in the resident's record. This documentation legally addresses the square footage deficiency for this specific resident.
CURRENT STATUS: Bedroom #7 is occupied by one resident with mobility needs and one resident without mobility needs. Based on the NP's documented justification, the room's 120.7 square feet is deemed appropriate and compliant for the current occupants, negating the deficiency.
IDENTIFICATION OF OTHERS: The owner has reviewed the mobility needs, room dimensions, and assignments for all other residents and verified that all other rooms are compliant or have a statement from the NP that deems that the rooms are safe and appropriate for each mobility needs person, in compliance with 2600.101.
*SYSTEMIC CHANGE: A new "Room Assignment and Mobility Needs" checklist will be implemented by 11-25-2025. This checklist "must" be completed and signed by the Admin. Ass. *prior* to any new admission or internal room transfer. This form will verify the resident's mobility needs against the room's measured square footage and include a section to document any necessary physician's justification for exceptions to square footage minimums, ensuring compliance *before* a move occurs. (DIRECTED: Beginning on 12/1/25: The checklist and resident assessments/support plans shall be reviewed at least monthly to ensure continued compliance with 2600.101c as resident mobiliy needs change. [redacted] 11/25/25).*

A SIGNED PHYSICIAN STATEMENT WILL BE OBTAINED BY 12-8-2025 TO VERIFY THAT AN EXEMPTION ON ROOM SIZE IS NOT CONTRAINDICATED FOR THE SAFETY AND WELL BEING OF THE RESIDENT. (DIRECTED: The signed physician statements shall be kept in all resident records.[redacted] 11/25/25).

Proposed Overall Completion Date: 12/08/2025

Directed Completion Date: *12/08/2025*

Implemented ([redacted] - 12/09/2025)

121a - Unobstructed Egress

3. 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

At 9:11am, a wheelchair was present in front of the emergency exit door near bedrooms #7 and #8, blocking this egress route.

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

IMMEDIATE CORRECTIVE ACTION: The wheelchair was immediately moved from the egress route on 11-7-2025,

121a - Unobstructed Egress (continued)

and the emergency exit path was cleared.
IDENTIFICATION OF OTHERS: The Admin. Ass. conducted an immediate house-wide inspection on 11-7-2025 to ensure all other hallways, doorways, and egress routes were unobstructed.
SYSTEMIC CHANGE: All staff will complete a mandatory in-service on "Egress Safety and Maintaining Clear Pathways" by 11-25-2025. This training will reinforce that no equipment, furniture, or supplies may be placed in hallways or in front of any exit door, even temporarily. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 11/25/25).
MONITORING AND QUALITY ASSURANCE: "Egress Route Inspection" has been added to the daily safety checklist for the Admin. Ass. and the designated Waking Staff to ensure all routes remain clear and unobstructed 24/7.

THE DAILY SAFETY CHECKS WILL BEGIN ON 11-25-2025 AND WILL BE DOCUMENTED ON THE CHECKLIST.

Proposed Overall Completion Date: 11/25/2025

Directed Completion Date: *11/25/2025*

Not Implemented *[redacted] - 12/09/2025)*