pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **HERITAGE MILLS PERSONAL CARE CENTER LLC**
LEGAL ENTITY

To operate **HERITAGE MILLS PERSONAL CARE CENTER**
NAME OF FACILITY OR AGENCY

Located at **846 EAST WICONISCO AVENUE, TOWER CITY, PA 17980**
(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 **60**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 30**

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 4, 2026** until **September 4, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **226361**

[redacted]

[redacted]

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

Sent via email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 4, 2026

[redacted]
Principal Partner
Heritage Mills Personal Care Center LLC
[redacted]

RE: Heritage Mills Personal Care Center
846 E. Wiconisco Avenue
Tower City, Pennsylvania 17980
License #226361

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on September 23, 2025, September 26, 2025, October 14, 2025, October 22, 2025, October 28, 2025, November 4, 2025, November 7, 2025 and January 6, 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 (LICENSE NO 226560) dated October 5, 2025 to October 5, 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 4, 2026 to SEPTEMBER 4, 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:

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)
187d	II	43	$5	$215	5 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 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,

[redacted]

[redacted]
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: *HERITAGE MILLS PERSONAL CARE CENTER* **License #**: *22636* **License Expiration**: *10/05/2026*

Address: *846 EAST WICONISCO AVENUE, TOWER CITY, PA 17980*

County: *SCHUYLKILL* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *HERITAGE MILLS PERSONAL CARE CENTER LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I 1* **Date**: *03/28/2012* **Issued By**: *Borough of Tower City*

Staffing Hours

Resident Support Staff: *1* **Total Daily Staff**: *67* **Waking Staff**: *50*

Inspection Information

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

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

Inspection Dates and Department Representative

10/28/2025 On Site: [redacted]
11/04/2025 Off Site: [redacted]
11/07/2025 Off Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *42*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *30* **Residents Served**: *21*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *42*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *24*
Have Physical Disability: *1*

Inspections / Reviews

10/28/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/12/2025*

12/09/2025 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

02/27/2026 - Bypass Document Submission

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

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

16c - Written Incident Report

1. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted]; 3x daily for hypotension. The medication was not administered to Resident [redacted] on [redacted], at 8:00 a.m. ,2:00 p.m. and 8:00 p.m. and on [redacted] at 8:00 a.m. because it was not on hand. The home did not report this incident to the department.

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

Immediately, the Administrator reported the incident to the Department's personal care home regional office. On 11/14/2025, the Administrator and the Director of Wellness were educated on the importance of reporting incidents within 24 hours in a manner designated by the Department. A weekly audit will be completed by the Administrator, ensuring all reportable incidents are reported within the 24-hour time frame. This audit will be ongoing for one month, starting 11/24/2025. The Administrator will be responsible to ensure compliance.

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

Not Implemented [redacted] - 01/13/2026)

65a - FS Orientation 1st Day

2. 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:

Description of Violation

Staff person A, whose first day of work was [redacted] and Staff person B, whose first day of work was [redacted] did not receive orientation on the following topics: (1) Evacuation procedures. (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable. (3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire. (4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable. (5) The location and use of fire extinguishers. (6) Smoke detectors and fire alarms. (7) Telephone use and notification of emergency services.

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

On 10/29/2025, Staff Person A and Staff Person B received orientation in general fire safety and emergency preparedness. On 11/14/2025, the Administrator and the Administrative Assistant were educated on the importance of employees receiving orientation in general fire safety and emergency preparedness prior to or during the first work day. A monthly audit will be completed by the Administrative Assistant ensuring all new hires received orientation in general fire safety and emergency preparedness within the appropriate timeframe. This audit will be ongoing for two months, starting 11/24/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Implemented [redacted] - 01/13/2026)

183b - Meds and Syringes Locked

3. 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] at 9:30 a.m., the nurse's office was unlocked, unattended, and accessible in the main lobby of the home. A file box filled with recently delivered medications was noted on a chair in the office.

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

Immediately the door to the nurse's office was closed and locked and inaccessible. On 11/14/2025, the Director of Wellness was educated on the importance of keeping prescription medications, OTC medications, CAM, and syringes in an area that is locked. A daily audit will be completed by the Administrator ensuring all prescription medications, OTC medications, CAM, and syringes are kept in an area that is locked. This audit will be ongoing for one month, starting 11/24/2025. The Administrator will be responsible to ensure compliance.

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

Not Implemented [redacted] - 01/13/2026)

183d - Prescription Current

4. 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] prescribed for Resident [redacted] was noted in a locked overflow narcotic drawer in the nurse's office. However, resident [redacted] had [redacted] on hospice, on resident [redacted]s date of death.
On [redacted]. and 2 blister packs o[redacted] prescribed for Resident [redacted] were noted in a locked overflow narcotic drawer in the nurses office. However, the resident had passed away on hospice, on resident [redacted]s date of [redacted]

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

Medications for Resident [redacted] and Resident [redacted] were destroyed in a drug buster by the Administrator and the Director of Wellness. A new policy was created and implemented for the storage and disposal of medications. On 11/17/2025, the Director of Wellness was educated on the importance of having current prescriptions, OTC, CAM, and sample medications in the home. On 11/17/2025, the Medication Technicians were educated on the new policy regarding storage and disposal of medications and implementation of policy. A monthly audit will be completed by the Director of Wellness ensuring only current prescriptions, OTC, CAM, and sample medications are kept in the home as well as ensuring implementation of the new storage and disposal of medications policy. This audit will be ongoing for two months, starting 11/24/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Implemented [redacted] - 01/20/2026)

185a - Implement Storage Procedures

5. Requirements

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

185a - Implement Storage Procedures *(continued)*

Description of Violation

On [redacted] at 9:40 a.m. several current "overflow" narcotic medication blister packs were noted in Staff person B's locked desk drawer. The home's policy indicates 2 staff are to count the narcotics and a second count sheet should be used for witness verification. There are no individual count sheets for the overflow narcotics and no signatures to verify that 2 staff are counting the medications at the change of every shift.

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

A new policy was created and implemented for the storage and disposal of medications. On 11/17/2025, the Director of Wellness and Medication Technicians were educated on the importance of following the home's policy regarding narcotic storage procedures. A monthly audit will be completed by the Administrator, ensuring the home's policy on proper procedures for narcotics is being implemented. This audit will be ongoing for two months, starting 11/24/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Not Implemented [redacted] - 01/13/2026)

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted] 3x daily for hypotension. The medication was not administered to Resident [redacted] on [redacted], at 8:00 a.m. ,2:00 p.m. and 8:00 p.m. and on [redacted] at 8:00 a.m. because it was not available in the home.

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

On 10/24/2025, medication was available for resident to have scheduled 2pm dose. On 11/17/2025, the Director of Wellness was educated on the importance of following prescriber's orders and ensuring medications are available for residents that is listed on their Medication Record. A weekly audit will be completed by the Director of Wellness, ensuring all prescriber's orders are being followed and medications are readily available. This audit will be ongoing for two months, starting 11/24/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Not Implemented [redacted] - 01/13/2026)

188c - Medication Error Documentation

8. Requirements

2600.
188.c. Documentation of medication errors and the prescriber's response shall be kept in the resident's record.

Description of Violation

Resident [redacted] is prescribed [redacted] 3x daily for hypotension. The medication was not administered to Resident [redacted] on [redacted], at 8:00 a.m. ,2:00 p.m. and 8:00 p.m. and on [redacted] at 8:00 a.m. because it was not available in the home. There is no documentation of the error in the resident's record.

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

Immediately, the medication error was documented in the resident's record. On 11/18/2025, the Administrator and

188c Medication Error Documentation (continued)

the Director of Wellness were educated on the importance of medication error documentation in the resident's records. A monthly audit will be completed by the Administrator, ensuring all medication errors are documented appropriately in the resident's records. This audit will be ongoing for two months, starting 11/24/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Implemented [redacted] - 01/13/2026)

254a - Records Discharge/Active

10. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On [redacted] at 9:30 a.m., the records for the home's residents were unlocked, unattended, and accessible in the nurse's office.

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

Immediately, the door to the nurse's office was closed, locked, and inaccessible. On 11/14/2025, the Director of Wellness was educated on the importance of maintaining records in a confidential manner. A daily audit will be completed by the Administrator, ensuring all records are maintained in a confidential manner, preventing unauthorized access. This audit will be ongoing for one month, starting 11/24/2025. The Administrator will be responsible to ensure compliance.

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

Implemented[redacted] - 01/13/2026)

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

Facility Information

Name: *HERITAGE MILLS PERSONAL CARE CENTER* **License #**: *22636* **License Expiration**: *10/05/2026*

Address: *846 EAST WICONISCO AVENUE, TOWER CITY, PA 17980*

County: *SCHUYLKILL* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *HERITAGE MILLS PERSONAL CARE CENTER LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I 1* **Date**: *03/28/2012* **Issued By**: *The Borough of Tower City*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *66* **Waking Staff**: *50*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *10/28/2025*

Inspection Dates and Department Representative

09/23/2025 On Site: [redacted]
09/26/2025 Off Site: [redacted]
10/14/2025 Off Site: [redacted]
10/22/2025 Off Site: [redacted]
10/28/2025 Off Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *43*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *30* **Residents Served**: *20*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *43*

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

Have Mobility Need: *23* **Have Physical Disability**: *1*

Inspections / Reviews

09/23/2025 Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/04/2025*

12/05/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/30/2025*

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

12/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/31/2025*

02/26/2026 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/30/2025*

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

16c Written Incident Report

1. Requirements

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

Description of Violation

On [redacted] at 2:18 p.m. and on [redacted] at 10:38 a.m. the homes fire alarm was activated and the local fire department responded to the home. The incidents were not reported to the Department.

Resident [redacted] has an order for [redacted] capsules to be administered daily at 12:00 p.m. The resident did not receive the medication from [redacted] through [redacted] as the medication was not available in the home. The medication error was not reported to the Department.

Resident [redacted] did not receive the prescribed [redacted] tablets and [redacted] tablets on [redacted] at 8 p.m. The medication error was not reported to the Department.

Resident [redacted] on Resident [redacted] date of [redacted] The home did not report the incident to the Department until [redacted].

On [redacted], Resident [redacted] had an unwitnessed fall and was diagnosed with a [redacted]. The home did not report the incident to the Department until [redacted]

Plan of Correction ***Accept [redacted] - 12/16/2025)***

On 12/03/2025 The incidents were reported to the Department's personal care home regional office for record. On 11/14/2025, the Administrator and the Director of Wellness were educated on the importance of reporting incidents within 24 hours in a manner designated by the Department. A weekly audit will be completed by the Administrator, ensuring all reportable incidents are reported within the 24-hour timeframe. This audit will be ongoing for one month, starting 11/24/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Not Implemented ([redacted] - 01/13/2026)

42e Telephone Access

2. Requirements

2600.
42.e. A resident shall have access to a telephone in the home to make calls in privacy. Nontoll calls shall be without charge to the resident.

42e Telephone Access *(continued)*

Description of Violation

The residents do not have access to a telephone in the home to make calls in privacy.

Plan of Correction ***Accept (RY - 12/16/2025)***

On 12/02/2025, the home made a cordless telephone accessible to the residents to make calls in privacy. On 11/25/2025, the Administrator was educated on the importance of residents having a telephone available to make calls in a private manner. A daily audit will be completed during business hours by the Administrator or designee. ensuring a telephone is accessible to the residents to make calls in privacy. This audit will be ongoing for one month, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Implemented (RY - 01/13/2026)

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 was hired by the home on [redacted]; however, the Pennsylvania State Police Criminal Background Check was not requested until [redacted]

Staff person B was hired on [redacted] the Pennsylvania State Police Criminal Background Check was not completed.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

On 09/23/2025, a Pennsylvania State Police Criminal Background Check was completed on Staff person B. On 11/25/2025, the Administrator and Administrative Assistant were educated on the importance of all employees receiving a criminal history check and ensuring it is within the appropriate timeframe. A monthly audit will be completed by the Administrative Assistant, ensuring all new hires receive a criminal history check and it is received within the appropriate timeframe. This audit will be ongoing for two months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

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

60a - Staff/Support Plan

4. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

From 11:00 p.m. to 7:00 a.m. on [redacted] and [redacted] the home had a census of 43 residents and had 3 direct care staff members working. Through interviews with staff, it was determined the home has 9 residents who would need the assistance of two staff persons to evacuate in the event of an emergency, and 17 residents needing either

60a Staff/Support Plan (continued)

the assistance of 1 person to evacuate or constant verbal queuing. 3 staff members is not enough staff to meet the needs of the residents in the event of an emergency as identified in their Residents Assessments and Support Plans.

Plan of Correction ***Accept [redacted] - 12/23/2025)***

As of today, 12/17/2025, the Administrator reviewed over the nursing schedule to ensure four people are scheduled for the night shift, 11pm 7:30am. The plan is to have nursing staff supplement to ensure the facility has four people on night shift. If the nursing staff is not able to supplement; ancillary staff, the Director of Wellness and Administrator will fill in to ensure the staffing needs are met. On 12/10/2025, the Director of Wellness (LPN) evaluated all current residents to determine their mobility needs in the event of an emergency. In addition12/08/2025 12/10/2025, direct care staff were interviewed, to identify any changes with the mobility needs of the residents. Resident support plans were updated based on findings. The facility is actively recruiting, hiring, and orienting new staff to ensure staffing needs are met to meet the needs of the current residents. The facility will utilize our nursing staff to supplement the days to assist with 4 staff members during the third shift as well as ancillary staff, the Director of Wellness, and the Administrator. The facility's goal is to continue hiring and orientating nursing staff to meet the needs of 4 staff members during the third shift hours. On 12/02/2025, the Administrator and Director of Wellness were educated on the importance of having the appropriate amount of staffing to meet the needs of the residents as specified in the resident's assessment and support plan. A bi weekly audit will be completed by the Director of Wellness, ensuring staffing is provided to meet the residents' needs as specified in the assessment and support plan. This audit will be ongoing for two months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/30/2025*

Implemented [redacted] - 01/13/2026)

65i - Training Record

5. 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 home's record of training for the year 2024 does not include the date the trainings were held.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

Annual training log is completed, showing the dates the trainings were held for the 2024 year. An audit was completed for the 2025 year training ensuring all dates were listed. On 11/25/2025, the Administrator and the Director of Wellness were educated on the importance of documenting the dates that trainings were held. A monthly audit will be completed by the Administrator, ensuring all records of training have the dates the training was held. This audit will be ongoing for two months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented [redacted] - 01/13/2026)

81b - Resident Personal Equipment

6. 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

Resident [redacted] utilizes an enabler bar. The enabler bar moved 6 inches left and 6 inches right, parallel to the mattress. The enabler bar was not securely attached.

Plan of Correction ***Accept [redacted] 12/16/2025)***

On 09/24/2025, Resident [redacted]'s enabler bar was securely attached. On 11/25/2025, all nursing staff were educated on the importance of ensuring all enabler bars are securely attached. A weekly audit will be completed by the Director of Wellness, ensuring all enabler bars are securely attached and free of hazards. This audit will be ongoing for one month, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Not Implemented [redacted] - 01/13/2026)

85a - Sanitary Conditions

7. Requirements

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

Description of Violation

Staff interviews indicated that Resident [redacted] room had feces from another resident on the floors from approximately 9:30 p.m. on [redacted] until after 11:00 a.m. on [redacted]

Plan of Correction ***Accept [redacted] - 12/16/2025)***

On 08/16/2025, Resident #[redacted]'s room was deep cleaned and sanitary conditions were in place. On 11/26/2025, all housekeeping staff and nursing staff were educated on the importance of maintaining sanitary conditions. A weekly audit will be completed by the Housekeeping Supervisor, ensuring sanitary conditions are maintained. This audit will be ongoing for one month, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Not Implemented [redacted] - 01/13/2026)

102i - Soap Dispenser

8. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On the sink in the shared bathroom of Room [redacted] and [redacted] there were two bars of soap. However, neither bar of soap was labeled with the resident's name.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

On 12/04/2025, the bar of soaps were appropriately labeled and soap dishes in place. All bathrooms were checked to ensure soap dishes are appropriately labeled and in use. On 11/25/2025, housekeeping staff were educated on the importance of bar soaps being clearly labeled for each resident who shares a bathroom. A weekly audit will be completed by the Housekeeping Supervisor ensuring all bar soaps are appropriately labeled if the bathroom is shared. This audit will be ongoing for one month, starting 12/05/2025. The Administrator will be responsible to

102i Soap Dispenser (continued)

ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

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

103e - Left Overs

10. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At approximately 1:30 p.m. there was an open bag of frozen broccoli in the kitchen freezer, and 3 bags of cereal in the kitchen area that were unlabeled and undated.

The home's kitchenette freezer in the secured dementia care unit contained a small open container of Friendly's Strawberry Shortcake Sunday, that was unlabeled and undated.

Plan of Correction ***Accept[redacted] 12/16/2025)***

On 09/24/2025, all food was appropriately labeled and dated. On 11/26/2025, all dietary and nursing staff were educated on the importance of ensuring all leftover food shall be labeled and dated. A weekly audit will be completed by the Dietary Supervisor, ensuring all leftover food is labeled and dated. This audit will be ongoing for one month, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Implemented [redacted] - 01/13/2026)

103i - Outdated Food

11. Requirements

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

Description of Violation

At approximately 1:30 p.m. there was a dented can of Solid Pack Pumpkin in the kitchen area.

Repeat Violation.[redacted]

Plan of Correction ***Accept[redacted] - 12/16/2025)***

On 09/23/2025, the dented can of Solid Pack Pumpkin was discarded. On 11/26/2025, all dietary staff were educated on the importance of not using dented cans. A weekly audit will be completed by the Dietary Supervisor, ensuring all dented cans are discarded. This audit will be ongoing for one month, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Implemented [redacted] - 01/13/2026)

121a - Unobstructed Egress

13. Requirements

121a - Unobstructed Egress *(continued)*

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 approximately 9:30 a.m., exterior door 2 would not open from the home's ground floor stairway emergency exit., preventing immediate egress in the event of an emergency.

Repeat Violation. [redacted] *et al*

Plan of Correction ***Accept*** [redacted] ***- 12/16/2025)***

On 09/23/2025, the Maintenance Supervisor fixed the exterior door 2 to ensure it would open. On 11/26/2025, the Maintenance Supervisor was educated on the importance of ensuring all doors are able to be open for immediate egress in the event of an emergency. A monthly audit will be completed by the Maintenance Supervisor, ensuring all doors have immediate egress in the event of an emergency. This audit will be ongoing for two months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

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

132a - Monthly Fire Drill

14. Requirements

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

Description of Violation

An unannounced fire drill was not held during the month of October 2024, November 2024, December 2024, March 2025, April 2025, May 2025 and September 2025.

Plan of Correction ***Accept*** [redacted] ***- 12/16/2025)***

A fire drill was held on 10/21/2025. On 11/26/2025, the Administrator was educated on the importance of ensuring fire drills are held at least once a month. A monthly audit will be completed by the Administrator ensuring a fire drill is held at least once a month. This audit will be ongoing for three months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

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

132c - Fire Drill Records

15. Requirements

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

Description of Violation

The fire drill record for the drill conducted on [redacted] *at 6:00 a.m. did not document the accurate date and time of*

132c - Fire Drill Records (continued)

the fire drill. The home's file alarm report notes the fire drill occurred on [redacted] at 9:27 a.m.

The fire drill record for the drill conducted on [redacted] at 4:15 p.m. did not document the accurate date and time of the fire drill. The home's file alarm report notes the fire drill occurred on [redacted] at 8:22 a.m.

Plan of Correction ***Accept[redacted] - 12/16/2025)***

A fire drill was held on 10/21/2025 and was appropriately documented on the fire drill record. On 11/26/2025, the Administrator was educated on the importance of appropriately documenting fire drills. A monthly audit will be completed by the Administrator, ensuring all fire drills are appropriately documented in the fire drill record. This audit will be ongoing for three months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented[redacted] 01/13/2026)

132e - Fire Drill Sleeping Hours

16. Requirements

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

Description of Violation

The last fire drill conducted during sleeping hours was on [redacted] at 5:30 a.m. The home has not conducted a sleeping hour fire drill since that date.

Plan of Correction ***Accept[redacted] - 12/16/2025)***

A sleeping hour fire drill was conducted on 10/21/2025 at 3:35am. On 11/26/2025, the Administrator was educated on the importance of conducting fire drills during sleeping hours. A monthly audit will be completed by the Administrator, ensuring fire drills are being held during sleeping hours, once every 6 months. This audit will be ongoing for three months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Implemented[redacted] - 01/13/2026)

141b1 - Annual Medical Evaluation

18. 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 was completed on [redacted]

Resident [redacted] medical evaluation dated [redacted] does not indicate if the residents' needs can be met in the personal care home.

141b1 - Annual Medical Evaluation *(continued)*

Plan of Correction ***Accept (- 12/23/2025)***

On 10/15/2025, facility received Resident s annual medical evaluation completed by physician. Date of in Person Evaluation was 09/03/2025 and Date of Form Completed was 10/13/2025. On 12/02/2025, Resident s physician wrote a letter stating the resident's needs can be met in the personal care home. An audit was completed on 11/26/2025, on all medical evaluations ensuring annual medical evaluations are completed and indicates the resident's needs can be met in the facility. On 11/26/2025, the Administrator was educated on the importance of having medical evaluations completed at least annually and the medical evaluation indicating the resident's needs can be met in the personal care home. A monthly audit will be completed by the Administrator, ensuring all medical evaluations are completed at least annually. This audit will be ongoing for two months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/30/2025*

Not Implemented 01/13/2026)

162c - Menus Posted

19. 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

The home did not have the menu posted for the weeks of and to

Plan of Correction ***Accept - 12/16/2025)***

On 09/24/2025, the appropriate menus were posted. On 11/26/2025, the Administrative Assistant was educated on the importance of menus being posted 1 week in advance in a conspicuous and public place in the home. A bi-weekly audit will be completed by the Administrative Assistant, ensuring menus are posted appropriately. This audit will be ongoing for one month, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Implemented 01/13/2026)

184a - Resident's Meds Labeled

20. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident has a PRN order for . The pharmacy label for resident 's indicates to take one tablet daily and does not reflect the correct dosing instructions.

Resident has a PRN order for tablets. The pharmacy label for resident # prescription indicates to take one tablet daily and does not reflect the correct dosing instructions.

Resident has an order for to be administered daily. The medication label states, "Please see attached

184a - Resident's Meds Labeled (continued)

for detailed instructions" and did not list the dosing instructions for the medication. No additional information was with the medication in the medication cart.

Plan of Correction ***Accept[redacted] - 12/23/2025)***

On 11/25/2025, the medications were appropriately labeled for the correct dosage and administration. On 12/02/2025, the Director of Wellness was educated on the importance of ensuring the resident's medication labels have the prescribed dosage and instructions for administration, as well as ensuring accuracy of label to Medication Record. A monthly audit will be completed by the Director of Wellness ensuring resident's medication labels are appropriately labeled. This audit will be ongoing for two months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/30/2025*

Implemented[redacted] - 01/13/2026)

184b - Labeling OTC/CAM

21. Requirements

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

A package of[redacted] supplements belonging to resident[redacted] was in the home's 2nd floor medication cart and was not labeled with the resident's name.

Plan of Correction ***Accept ([redacted] - 12/23/2025)***

On 09/24/2025, the medication was labeled with the resident's name. On 11/26/2025, the Director of Wellness was educated on the importance of labeling OTC meds with the resident's name. A monthly audit will be completed by the Director of Wellness, ensuring all OTC meds are appropriately labeled with the resident's name. This audit will be ongoing for two months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/30/2025*

Not Implemented ([redacted] - 01/13/2026)

185a - Implement Storage Procedures

22. 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[redacted] has an order for[redacted] checks daily at 8:00 a.m., 12:00 p.m. and 5:00 p.m. On[redacted] at 12:00 p.m., the resident had a blood glucose reading of[redacted] noted in the glucometer and it was documented as[redacted] on the medication administration record. On[redacted] at 12:00 p.m., the resident had a[redacted] reading of[redacted] noted in the resident's glucometer and it was documented as[redacted] on the resident's medication administration record.

Repeat Violation:[redacted]

185a - Implement Storage Procedures (continued)

Plan of Correction ***Accept[redacted] - 12/23/2025)***

A new policy was created and implemented for the storage of medications. On 11/17/2025, the Medication Technicians were educated on the importance of following the new policy. On 12/02/2025, the Medication Technicians were educated on ensuring the accuracy of documenting resident's blood glucose readings. A monthly audit will be completed by the Director of Wellness ensuring the new policy is being followed as well as proper documentation of blood glucose readings. This audit will be ongoing for two months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/30/2025*

Not Implemented ([redacted] - 01/13/2026)

187c - Refusal of Medication

23. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On [redacted] and [redacted] at 8:00 a.m., resident [redacted] refused to take a scheduled dose of [redacted]. The home did not contact the resident's physician regarding the refusal.

Repeat Violation [redacted] et al

Plan of Correction ***Accept ([redacted] - 12/16/2025)***

On 09/23/2025, the resident's physician was notified of the refusal. On 12/01/2025, the Director of Wellness was educated on the importance of informing the resident's physician for a refusal of a medication. A bi-weekly audit will be completed by the Director of Wellness ensuring resident's physicians are notified of refusal of medications. This audit will be ongoing for two months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Not Implemented[redacted] 01/13/2026)

187d - Follow Prescriber's Orders

24. Requirements

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

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

Description of Violation

Resident [redacted] has an order for [redacted] capsules to be administered daily at 12:00 p.m. The resident did not receive the medication from [redacted] through [redacted] as the medication was not available in the home.

Resident [redacted] has order for [redacted] per 15 ml solution, [redacted] tablets, [redacted] tablets, [redacted] tablets [redacted] tablets and [redacted] tablets to be administered daily. The resident did not receive the medications on [redacted] at 8p.m.

Resident [redacted] has an order [redacted], administer [redacted] 3 times a day plus sliding scale: [redacted] units. [redacted] or not eating, do not give. [redacted] add [redacted] units. [redacted] add [redacted] units. [redacted] add [redacted] units. [redacted] give [redacted] units. Call Endo if [redacted] Sugar is [redacted] may give correction of [redacted] units, wait 20-30 minutes if sugar has not improved [redacted] go to ER. On [redacted] at 8:00 a.m., [redacted] at 8:00 a.m. [redacted] at 8:00 a.m. the resident's [redacted] [redacted] tested over [redacted] the prescriber was not called. On [redacted] at 8:00 a.m. the resident's [redacted] tested [redacted], the resident did not go to the ER.

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

Plan of Correction ***Accept [redacted] - 12/23/2025)***

On 09/19/2025, medication was available for Resident [redacted]. On 12/02/2025, the Director of Wellness and Medication Technicians were educated on the importance of following prescriber's orders. On 12/02/2025, the Director of Wellness was educated on the importance of ensuring medications are available for residents that is listed on their Medication Record. A weekly audit will be completed by the Director of Wellness, ensuring all prescriber's orders are being followed and medications are readily available. This audit will be ongoing for two months, starting 11/24/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/30/2025*

Not Implemented ([redacted] - 01/13/2026)

188b - Medication Error Reporting

25. Requirements

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

Description of Violation

Resident [redacted] has an order for [redacted] capsules to be administered daily at 12:00 p.m. The Resident resident did not receive the medication from [redacted] through [redacted] as the medication was not available in the home. The

188b - Medication Error Reporting (continued)

medication error was not reported to the resident's physician until [redacted].

Resident [redacted] has order for [redacted] per [redacted], [redacted] tablets, [redacted] tablets, [redacted] tablets [redacted] tablets and [redacted] tablets. The resident did not receive the medications on [redacted] at 8:00 p.m. The resident's physician was not notified regarding the medication error.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

On 09/23/2025, the physicians were notified of the medication errors for record. On 12/01/2025, the Director of Wellness was educated on the importance of informing the physician within the appropriate timeframe of medication errors. A monthly audit will be completed by the Director of Wellness ensuring all medication errors are reported to the physician in the appropriate timeframe. This audit will be ongoing for three months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2025*

Not Implemented [redacted] - 01/13/2026)

227d - Support Plan Medical/Dental

27. Requirements

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

Description of Violation

Resident [redacted] utilizes an enabler bar to reposition and transfer. The resident's assessment dated [redacted] notes the use of the enabler bar. The support plan does not indicate any risks associated with the device, the resident's ability to use the device safely for the intended purpose or if a cover is required per FDA guidelines.

Plan of Correction ***Accept [redacted] - 12/16/2025)***

On 12/02/2025, the support plan was updated to provide the appropriate documentation. On 12/01/2025, the Administrator was educated on the importance of documenting the appropriate information on the support plan for the use of an enabler bar. A monthly audit will be completed by the Administrator, ensuring the appropriate documentation is in the support plan for use of enabler bar. This audit will be ongoing for two months, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Implemented [redacted] - 01/13/2026)

233c - Key-Locking Devices

28. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near stairwell exit #2 in the Secure Dementia Care Unit.

Repeat Violation.[redacted]

Plan of Correction ***Accept ([redacted] - 12/16/2025)***

On 12/03/2025, directions were conspicuously posted near stairwell exit #2 in the Secure Dementia Care Unit. On 12/01/2025, the Administrator was educated on the importance of having the directions for operating the home's locking mechanism posted near the stairwells on the Secure Dementia Care Unit. A weekly audit will be completed by the Administrator ensuring the directions are posted at all stairwells on the Secure Dementia Care Unit. This audit will be ongoing for one month, starting 12/05/2025. The Administrator will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/19/2025*

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