pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail: [redacted]

MAILING DATE: March 19, 2026

[redacted] MANAGER
DEVONHOUSE SENIOR LIVING LLC
[redacted]

RE: DEVONHOUSE SENIOR LIVING
1930 BEVIN DRIVE
ALLENTOWN, PA, 18103
LICENSE/COC#: 23115

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 29, 2025, and November 7, 2025, of the above facility, we have determined that your submitted plan of correction is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[redacted]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *DEVONHOUSE SENIOR LIVING* **License #**: *23115* **License Expiration**: *11/09/2026*

Address: *1930 BEVIN DRIVE, ALLENTOWN, PA 18103*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *DEVONHOUSE SENIOR LIVING LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type	Date	Issued By
C-2 LP	10/20/1989	DLI
I-1	01/08/2008	Salisbury Township

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *71* **Waking Staff**: *53*

Inspection Information

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

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

Inspection Dates and Department Representative

10/29/2025 - On-Site:
11/07/2025 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *63*

Secured Dementia Care Unit

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

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *63*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *8* **Have Physical Disability**: *1*

Inspections / Reviews

10/29/2025 - Full

Lead Inspector: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *12/06/2025*

12/12/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/15/2026*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *12/19/2025*

12/26/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/15/2026*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *01/15/2026*

03/19/2026 - Document Submission

Submitted By: [redacted]
Date Submitted: *01/15/2026*
Reviewer: [redacted]
Follow-Up Type: *Exception*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The home's License Inspection Summary (LIS) dated 12/19/24 was not posted in a conspicuous and public place in the home; the report was stored in an unlabeled desk drawer. Also, the home's LIS reports dated 1/22/25, and 2/7/25 et al were not posted or stored in the drawer with the report dated 12/19/24.

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

The home will post the current license inspection summary issued by the department and all concurring license inspection summaries throughout the year. The postings will be in a conspicuous and public place in the home. Signs will be posted directing where inspection summaries are located and that they will be available upon request. Executive Director or designee will be responsible. Completion date will be 12/19/25.

Moving forward each month, the Executive Director or designee will be responsible for ensuring that all inspection summaries posted are current and up to date. Also, they are available for inspection upon request. Completion date will be 12/19/25.

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

Implemented (█ - 03/19/2026)

16c - Written Incident Report

2. Requirements

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

Description of Violation

Resident #16 has an order for Gabapentin 100 mg daily at bedtime. The medication was administered on 10/29/25 at 3:59 p.m. An incident report was not submitted to the Department regarding the medication error.

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

Resident #16's medication error report completed 12/2/25 and submitted to the Department of Human Services by the Director of Nursing.
Executive Director to educate Director of Nursing, LPN's and medication technicians on immediately reporting medication errors to Executive Director to report to the department as required on 12/29/25. Executive Director or Designee to be responsible.

Licensee's Proposed Overall Completion Date: *12/18/2025*

Implemented (█ - 03/10/2026)

17 - Record Confidentiality

3. Requirements

17 - Record Confidentiality *(continued)*

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At 9:30 a.m. the resident privacy coding document was attached to the LIS dated 12/19/24. The LIS was noted in an unlocked desk drawer in the entryway of the home. The privacy coding document exposes confidential information of the residents.

At approximately 9:20 a.m. in the 100 hallway, the computer was unlocked and unattended with resident confidential information displayed.

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

17- The Executive Director or designee will remove the privacy coding document from the postings. Completion date will be 12/19/25. Moving forward the Executive Director or Designee will check monthly to ensure privacy coding documents are not posted. Completion date 12/19/25.

17- All nurses and med-techs working a cart will be in-serviced on properly locking the computer screen, when leaving the cart. Director of Nursing or designee to complete by 12/23/25.

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

Not Implemented (- 03/19/2026)

18 - Compliance With Laws

4. 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

A carbon monoxide detector was not located at least 15 feet from the fossil fuel boiler, as per The Care Facility Carbon Monoxide Alarm Standards Act.

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

The carbon monoxide monitor was not located in the basement. A new carbon monoxide monitor will be purchased and located in the basement 15 feet from the fossil fuel boiler. The carbon monoxide monitors will be checked annually for compliance. The Executive Director or designee will complete. Completion date is 12/15/25.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Implemented (- 01/23/2026)

51 - Criminal Background Check

5. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person B's first day of work was [redacted]. The Pennsylvania State Police Criminal Background Check was completed on [redacted]

Staff person C's first day of work was [redacted]. The Pennsylvania State Police Criminal Background Check was completed on [redacted]

Staff person D's first day of work was [redacted]. The Pennsylvania State Police Criminal Background Check was completed on [redacted]

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

All criminal history checks will be completed in accordance with the Older Adult Protective Services Act. The Act states that all criminal history checks will be completed prior to the start of employment. Office Manager or designee to complete. Completion date 12/15/25. Moving forward, no staff person will begin employment without a criminal history check on the first day of employment. Office Manager or designee will maintain a log of each new employee and the dates of their criminal background checks to maintain compliance. Office Manager or designee to complete. Completion date 12/15/25.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Implemented ([redacted] - 01/23/2026)

63a - First Aid/CPR Training

6. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

The homes current census is 63. The home is required to have 2 staff persons certified in First Aid and CPR at all times. On 10/11/25 and 10/25/25 no one was certified on 3rd shift.

Repeat violation: 12/19/24

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

Current schedule audited by the Director of Nursing on 12/16/25 to confirm one staff person for every 50 residents who is trained in first aide and certified in obstructed airway techniques and CPR is present in the home at all times. The Director or Nursing or designee will review each schedule daily beginning 12/17/25 to confirm CPR and first aid staffing compliance is maintained. A CPR and First Aid certifications tracking form initiated on 1/16/25 by the Director of Nursing for each certified employee to ensure certifications are kept current. First CPR and First Aid training will be scheduled by 1/15/2026 by the Director of Nursing. Director of Nursing will be responsible.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented ([redacted] - 01/23/2026)

65f - Training Topics

7. Requirements

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

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Staff person H hired ██████ did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan in 2024.

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

Staff person H will be trained on how to meet the needs of a resident as described in the preadmission screening form, assessment tool, medical evaluation and support plan by 12/20/25. Executive Director or designee will be responsible. Completion date is 1/6/2026. Moving forward all staff will be trained in how to meet the needs of a resident as described in the preadmission screening form, assessment tool, medical evaluation and support plan on an annual basis. Educational tracking forms will be kept on each employee. Executive Director or designee will complete. Completion date is 1/6/2026.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Not Implemented (██ - 01/23/2026)

65g - Annual Training Content

8. Requirements

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
5. Falls and accident prevention.

Description of Violation

Staff persons H and I hired ██████ did not receive training in fire safety and emergency preparedness in 2024.

Staff person F hired ██████ did not receive training in falls and accident prevention in 2024.

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

65g-Staff person H and staff person I will be trained in fire safety and emergency preparedness by 1/6/2026. Executive Director or designee to complete. Moving forward all staff will be trained in fire safety and emergency preparedness on an annual basis.

65g-Staff person F will be trained in falls and accident prevention by 1/6/26. Executive Director or designee to complete. Moving forward all staff will be trained in accident and fall prevention on an annual basis. Executive Director or designee to complete. Completion date is 1/6/2026.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Not Implemented (██ - 03/19/2026)

82a - Poisonous Materials

10. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

At 9:30 a.m. an unlabeled plastic spray bottle was found with a pink liquid stored in it.

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

All unlabeled plastic spray bottles will be collected and discarded by 12/6/2025. Executive Director or designee will be responsible. Moving forward only labeled spray bottles will be used explaining its content and usage. Weekly checks will be done to remove any unlabeled bottles. Executive Director or designee will be responsible. Completion date will be 1/6/2026.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 01/23/2026)

82c - Locking Poisonous Materials

11. Requirements

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

Description of Violation

At 9:30 a.m. a jug of Excelente multipurpose cleaner with a label that indicates "harmful if swallowed get medical attention" was unlocked, unattended, and accessible to residents in the 400 hallway. Not all residents of the home, including Resident #2, have been assessed capable of recognizing and using poisons safely.

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

Locked cabinets will be provided on each hallway. All bottled chemicals will be stored in these locked units in between usage. Executive Director or designee will be responsible. Completion date 1/6/2026. Moving forward weekly checks will occur assuring all labeled bottles are locked away. Executive Director or designee will be responsible. Completion date is 1/6/2025.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 01/23/2026)

85a - Sanitary Conditions

12. Requirements

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

Description of Violation

At 10:00 a.m. there were several scoops of ice cream found on the bottom of the ice cream freezer next to the ice cream cartons.

85a - Sanitary Conditions *(continued)*

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

Ice cream freezer will be cleaned out completely. Dining Director or designee will complete. Completion date will be 12/5/2025. Going forward, a weekly audit will be completed checking that the ice cream freezer is clean and sanitary to department standards. Dining director or designee to complete. Completion date is 1/6/2026.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 03/19/2026)

85e - Trash Outside Home

13. Requirements

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

Description of Violation

At 2:30 p.m. the home's dumpster lid was left open and there was also a bag of garbage sitting on the ground next to the dumpster.

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

All staff will be in-serviced on proper dumpster usage. The education will include the placing of trash bags inside the dumpster and the closing of all lids after usage of dumpster. Executive Director or designee will be responsible. Completion date 1/6/2026. Going forward there will be a daily check that trash is in dumpster and lids are closed. Executive director or designee will be responsible. Completion date is 1/6/2026.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 01/23/2026)

101j7 - Lighting/Operable Lamp

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

At 3:12 p.m. Resident #1 did not have access to a source of light that can be turned on and off at bedside.

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

101j7- Resident #1 was provided with a lamp, at bedside, during the inspection. Executive Director or designee have completed. Going forward all room set-ups will include a lamp at bedside. A monthly checklist will be created to inspect each room, to make sure each room has a lamp at bedside. Executive Director or designee will complete. Completion date will be 1/6/2026.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Not Implemented (█ - 01/23/2026)

109b - Rabies Vaccination

15. Requirements

2600.

109b - Rabies Vaccination *(continued)*

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

Stormy the goldendoodle did not have a current rabies vaccination at the home.

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

During the survey a current rabies vaccination was received for Stormy from veterinarian. Activities Director or designee have completed. Completion date was 10/29/25. Moving forward, a rabies record will be kept for each dog and cat that visits the home. Activities Director or designee will be responsible. Completion date 1/6/2026.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (- 01/23/2026)

132d - Evacuation

17. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

According to staff interviews, and the administrator, the residents are not evacuating into a fire safe area if they are not in the 'fire area' during fire drills. According to Staff A, the person running the fire drills, the time is being recorded from the time the drill goes off until the residents in the 'fire area' is cleared, not when all the residents are out of their room in a fire safe area or to the outside of the building.

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

Fire drills will be held monthly with staggered times and staggered dates to meet compliance requirements. Maintenance Director or designee will oversee. Completion dates will be 1/15/2026. Going forward fire drills will be held monthly with staggered dates and staggered times to meet compliance requirements. Also drills will include all residents being moved to fire safe areas to meet compliance. Also, all drills will allow fire drill time to continue until resident participation count is complete. Maintenance Director or designee will be responsible. Completion date will be 1/15/2026.

Proposed Overall Completion Date: 01/15/2026

(Directed)
In addition to the above noted plan: Effective immediately all residents will be evacuated to an internal fire safe area or to the outside of the building during fire drills. The time for evacuation will be when all residents are outside of their bedrooms in an internal fire safe area or to the outside of the building within the time given by the fire safety expert. The Administrator will observe the unannounced fire drills for 6 months to ensure they are being conducted as required, any problems will be immediately addressed. The Administrator will initial the fire drill log after the observations. All staff persons will be trained on the fire drill requirements.

Directed Completion Date: *01/15/2026*

132d - Evacuation *(continued)*

Implemented (█ - 01/23/2026)

132h - Designated Meeting Place

18. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During a resident interview, resident #3 indicated they are not evacuated from their room during fire drills.

According to the administrator, during fire drills, residents do not evacuate into a fire safe area if they are not in the 'fire area' they remain in the threshold of their rooms.

Plan of Correction ***Directed (█ - 12/23/2025)***

Fire drills will be held monthly with staggered times and staggered dates to meet compliance requirements. Maintenance Director or designee will oversee. Completion dates will be 1/15/2026. Going forward fire drills will be held monthly with staggered dates and staggered time to meet compliance requirements. Also drills will include all residents being moved to fire safe areas, including all residents being removed from their rooms, to meet compliance. Also, all drills allow fire drill time to continue until resident participation count is complete. Maintenance Director or designee will be responsible. Completion date will be 1/15/2026.

Proposed Overall Completion Date: 01/15/2026

(Directed)
In addition to the above noted plan: Effective immediately all residents will be evacuated to an internal fire safe area or to the outside of the building during fire drills. The time for evacuation will be when all residents are outside of their bedrooms in an internal fire safe area or to the outside of the building. The Administrator will observe the unannounced fire drills for 6 months to ensure they are being conducted as required, any problems will be immediately addressed. The Administrator will initial the fire drill log after the observations. All staff persons will be trained on the fire drill requirements.

Directed Completion Date: *01/15/2026*

Implemented (█ - 01/23/2026)

182b - Prescription Medication

19. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

182b - Prescription Medication *(continued)*

Description of Violation

On 10/1/2025 at 6:00 a.m. staff person E administered acetaminophen to Resident #17. Staff person E is not trained to administer medication.

On 10/1/2025 at 10:00 p.m. staff person F administered acetaminophen to Resident #17. Staff person F is not trained to administer medication.

On 10/28/2025 at 8:00 a.m. staff person G administered acetaminophen to Resident #17. Staff person G is not trained to administer medication.

On 10/12/2025 at 8:00 a.m. staff person K administered acetaminophen to Resident #17. Staff person K is not trained to administer medication.

On 10/28/2025 at 2:00 p.m. staff person J administered acetaminophen to Resident #17. Staff person J is not trained to administer medication.

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

Staff person E, F G, K and J will complete medication observation certification by 1/15/2025. All Medication Administration Technicians certifications will be audited monthly by the Director of Nursing for compliance beginning 1/15/26 for 3 months. Medication Administration Technician tracking form was created by the Director of Nursing to maintain compliance. Director of Nursing will be responsible for on-going compliance.

Proposed Overall Completion Date: 01/15/2026

(Directed)
All staff persons administering medications will complete the Department approved medication administration course. This training should also include other routes of administration other than oral.

Directed Completion Date: *01/15/2026*

Implemented (- 03/19/2026)

183b - Meds and Syringes Locked

20. Requirements

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

Description of Violation

At approximately 9:19 a.m. a plastic container of medications was noted unlocked and accessible under the sink in the 100 hallway.

183b - Meds and Syringes Locked (continued)

At approximately 9:26 a.m. a plastic container of medications was noted unlocked and accessible under the sink in the 200 hallway.

At approximately 9:33 a.m. a plastic container with calomeseptine ointment belonging to Resident #18 was noted unlocked and accessible under the sink in the 400 hallway.

At 3:42 p.m. a bottle of Excedrin was found in resident #3's room unlocked and accessible on a bedside table. Resident #3 is unable to self-administer medication.

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

Medications unlocked in the hallways 100, 200, and 400 were removed by the Director of Nursing on 10/29/2025 and secured in medication carts. Bottle of Excedrin was removed from resident #3's room and destroyed by Director of Nursing on 10/29/2025. All nursing staff was educated by the Director of Nursing on 12/2/2025 on requirement of medications. OTC medications CAM and syringes need to be kept in an area or container that is locked. Director of Nursing to perform weekly audit of hallway cabinets and rooms for compliance x4 weeks beginning 12/8/2025. Director of Nursing will be responsible for on-going compliance.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented (█ - 01/23/2026)

183d - Prescription Current

21. Requirements

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

Description of Violation

A tube of zinc oxide paste and prevent ointment were located in a drawer near the sink in the 400 hallway. Staff person L reported that they belonged to residents that were receiving hospice services that no longer reside at the home.

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

Tube of zinc oxide paste was removed and discarded by Director of Nursing on 10/29/2025. All nursing staff inserviced on 12/2/2025 by the Director of Nursing on requirement of any current prescriptions. OTC, sample, and CAM for individuals living in the home may be kept in the home and removal from home upon discharge. Monthly cart audits initiated 12/2/25 to be completed by Director of Nursing or Designee x 3 months to monitor compliance of removal of all prescriptions, OTC, sample, and CAM for individuals from home upon discharge. The Director of Nursing will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented (█ - 01/23/2026)

183e - Storing Medications

22. Requirements

2600.

183e - Storing Medications *(continued)*

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

Description of Violation

On 10/29/25 Resident #4 had an open Glargin YFGN 1000/ml injection pen open in the medication cart. There was no date when the pen was opened. According to the manufacturer's instructions, the pen should be dated when opened and discarded after 28 days.

On 10/29/25 Resident #5 had an open Tojeo Solo Inject 300ml pen in the medication cart. There was no date when the pen was opened. According to the manufacturer's instructions, the pen should be dated when opened and discarded after 42 days.

On 10/29/25 Resident #6 had an open Humalog pen 100 unit/ml open in the cart. The pen was opened on 9/30/25. The manufacturer's instructions indicate the pen should be discarded after being open 28 days.

Resident #19's lid to the bottle of Vitamin B12 was broke off, the vitamin B12 was not covered and open to the air.

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

Resident #4 Glargine pen discarded, Resident #5 toujeo pen discarded, Resident #6 humalog pen discarded, Resident #19 vitamin B12 discarded and replaced by Director of Nursing on 10/29/2025. All LPNs and Medication Administration Technicians inserviced on 12/29/2025 by Director of Nursing on regulation 183e and the proper storage of prescription medications. OTC meds and CAM to be stored in an organized manner under proper conditions of sanitation, temperature, and lights and in accordance with the manufacturer's instructions including dating of insulin upon opening. Monthly cart audits beginning 12/22/25 x3 months will be completed by the Director of Nursing or Designee. The Director of Nursing is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Not Implemented (█ - 01/23/2026)

184a - Resident's Meds Labeled

23. 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

A bottle of ammonium lactate 12% lotion and Resident #20's silver sulfadiazine cream USP 1% was noted in the container found under the 100-hallway sink and did not have a pharmacy label attached. Mupirocin ointment USP

184a - Resident's Meds Labeled (continued)

2% was also noted under the same sink but the pharmacy label was not able to be read.

Resident #5's Novolog flexpen did not have a pharmacy label attached.

Resident #11 has a PRN order for guaifenesin 400 mg one tablet every 8 hours, the label to the medication notes 4 times daily. The label is incorrect.

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

The bottle of ammonium lactate 12% was discarded, resident #20's silver sulfadiazine cream was discarded, mupirocin ointment 2% was discarded, resident #5 novolog pen was discarded, and resident #11 guaifenesin direction change sticker was applied all completed by the Director of Nursing on 10/29/2025. Resident #20's silver sulfadiazine cream and resident #5 novolog pen replaced by pharmacy on 10/29/2025. All LPNs and Medication Administration Technicians inserviced on regulation 184a on proper labeling of prescription medications by the Director of Nursing on 12/2/2025. Monthly medication cart audits to monitor proper labeling of medications initiated 12/2/25 for 3 months will be completed by the Director of Nursing or Designee. The Director of Nursing is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented (█ - 01/23/2026)

184b - Labeling OTC/CAM

24. 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

Resident #19's fiber therapy, ibuprofen 200mg and vitamin B12 did not include the resident's name.

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

Resident #19’s fiber therapy, ibuprofen 200mg and vitamin B12 were labeled with the resident’s name by the Director of Nursing on 10/29/25. All LPN’s and Medication Administration Technicians inserviced by the Director of Nursing on 12/2/25 on regulation 184b and need to identify OTC medications and CAM belonging to the resident need to include the resident’s name. Monthly cart audits initiated 12/2/25 x 3 months will be completed by the Director of Nursing or designee to monitor compliance on regulation 184b. Director of Nursing or designee are responsible for ongoing compliance.

184b - Labeling OTC/CAM (continued)

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented (- 01/23/2026)

185a - Implement Storage Procedures

25. 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

On 10/29/25 at 2:52 p.m. Resident #5's glucometer indicated 9/24/25 at 2:14 p.m.

On 10/29/25 at 3:10p.m. Resident #6's glucometer indicated 10/11/25 at 12:17 p.m.

The facility policy indicates that at shift change the arriving and leaving staff must sign the Controlled Substance Shift change log. On 10/23/2025 at 8:00 a.m. the off going staff did not sign the Controlled Substance Shift change log. On 3:00 p.m., the oncoming staff did not sign the Controlled Substance Shift change log. On 10/24/25, 10/25/25, 10/26/25, and10/27/25, at 6:00a.m. the off going staff did not sign the Controlled Substance Shift change log. On 10/24/25, 10/25/25, 10/26/25, 10/27/25, and 10/28/25 at 11:00 p.m. the oncoming staff did not sign the Controlled Substance change log.

Staff are not indicating the administration of narcotics on the Resident Narcotic Count Sheet, as per their policy. On 10/29/25, Resident #7 is prescribed Tramadol 50 mg, take 1 tab by mouth 2 times per day, the Narcotic Count Sheet indicated there were 8 pills, the narcotic count was 7. On 10/29/25, Resident #8 is prescribed Lorazepam 0.5 mg, the Narcotic Count Sheet indicated there were 7 pills, the narcotic count was 6. Resident #9 is prescribed Lorazepam 0.5mg, the Narcotic Count Sheet indicated 13 pills, the narcotic count was 12.

Resident #9 is prescribed Morphine Sulfate 100 / 5 ml 0.25 (5mg) by mouth every 3 hours as needed. On 10/29/25 the Narcotic Count Log indicated there should be 21.5 ml in the bottle, there was 18ml in the bottle.

On 10/22/25 at 9:34 p.m. Resident #6's blood glucose reading was 259, however 283 was recorded on the medication administration record.

Resident #10 is prescribed Triamcinolone Oin 0.025, apply to left ear and right cheek as needed. The medication was not available in the home.

Resident #6 is prescribed Glucagon injection, 1mg sub q, every 24 hours as needed for blood sugar less than 70. The

185a - Implement Storage Procedures (continued)

medication was not available in the home.

Repeat violation: 12/19/24

Plan of Correction ***Accept (█ - 12/26/2025)***

Director of Nursing on 12/2/25 calibrated Resident #5 and #6's glucometer to correct date and time.

Director of Nursing had required staff to make corrections on 10/23/25 off going staff sign the log, at 3pm the oncoming staff sign the log also, on 10/24, 10/25, 10/26 and 10/27 at 6am and 10/24, 10/25. 10/27 and 10/28 at 11pm.
Resident #7 prescribed Tramadol signed out on narcotic sheet by Director of Nursing on 10/29 at 3pm.
Resident #8 prescribed Ativan signed out on a narcotic sheet by Director of Nursing on 10/29 at 3pm.
Resident #9 prescribed Ativan signed out on a narcotic sheet by Director of Nursing on 10/29 at 3pm.
Resident #9 prescribed Morphine count log incorrect related to spillage, Error reported, and medication was destroyed and replaced by pharmacy on 10/29, Director of Nursing completed.
Resident #6's Blood sugar clarified by Director of Nursing on 10/29 via a nurse's note.
Resident #10's prescribed Triamcinolone ointment was reordered on 10/29 by Director of Nursing and received on 10/30.
Resident #6's prescribed glucagon injection was reordered on 10/29 by Director of Nursing and received on 10/30.
Director of Nursing or designee to audit 30% of residents medications via MAR to cart audit weekly x 1 months then monthly x 3 months beginning 12/2/25. Director of Nursing to initiate glucometer audit on 12/2/25 to be completed by Director of Nursing or designee weekly x 1 months then monthly x 3 months to ensure correct calibration and glucose documentation. Director of Nursing to initiate Controlled Substance shift change log audit to be completed by the Director of Nursing or designee weekly x 1 month then monthly x 3 months beginning 12/2/25. Director of

185a - Implement Storage Procedures (continued)

Nursing to provide education to Med Techs and LPN's on reordering medications, medication availability, medical equipment and regulation 2600.185A by 12/29/25. Director of Nursing responsible for ongoing compliance .

Licensee's Proposed Overall Completion Date: *01/15/2026*

Not Implemented (█ - 01/23/2026)

187a - Medication Record

26. Requirements

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

8. Frequency of administration.
9. Administration times.

Description of Violation

Resident #17 has an order for hydralazine 50 mg three times a day. The medication administration record does not include the morning dose.

Plan of Correction ***Accept (█ - 12/26/2025)***

MAR corrected to include morning dose by pharmacy on 12/3/25. Director of Nursing spoke with Pharmacy on 12/3/25 and requested pharmacy to use Military time only. LPN's and Medication Technicians educated on regulation 187a; A medication record shall be kept to include the following for each resident for whom medications are administered: frequency of administration and administration times by Director of Nursing on 12/29/25. Director of Nursing or designee to audit 30% of resident's medications via MAR to cart audit weekly x 1 month then monthly x 3 months beginning 12/2/25.Director of Nursing responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented (█ - 01/23/2026)

187d - Follow Prescriber's Orders

27. Requirements

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

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

Description of Violation

Resident #16 has an order for Gabapentin 100 mg daily at bedtime. The medication was administered on 10/29/25 at 3:59 p.m.

Plan of Correction ***Accept (- 12/26/2025)***

Staff member F administered Resident #16's Gabapentin 100mg at 3:59pm. Staff member F counseled on following the directions of the prescriber by the Director of Nursing on 10/30/25. Director of Nursing or designee to audit 30% of resident medications via MAR documentation for correctly following the directions of the prescriber, audit to be completed weekly x1 month then monthly x 3 months. Cart audit starting on 12/2/25. Director of Nursing or designee will be responsible.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Not Implemented (- 03/19/2026)

227c - Support Plan Revision

30. Requirements

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

Description of Violation

Resident #15's support plan dated did not include that the resident self-administers their own medications with no assistance; the support plan indicated that the resident "chooses to use resident services".

Plan of Correction ***Accept (- 12/26/2025)***

Director of Nursing updated Resident #15's support plan on 10/29/25 to include that resident administers medications without assistance
Executive Director educated Director of Nursing and LPN's to revise support plan based on changes in the resident's needs 12/29/25. The Director of Nursing will audit 30% of resident's support plans weekly x 1 month then monthly x three months for compliance of updating upon changes in the resident's needs beginning 12/29/25. Executive Director or designee is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented (- 01/23/2026)

251b - Record Entries Legible

32. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

The record of financial transactions form for Resident #21 had correction tape next to the 12/21/24 and 3/25 transactions in the amount deposited column.

Plan of Correction ***Accept (- 12/26/2025)***

The employee responsible for working with financial records of residents was verbally instructed to no longer use any white out products with resident records. Executive Director or designee had verbal conversation. Completion date

251b - Record Entries Legible (continued)

was 10/29/25. Going forward an in-service will be conducted with employe on proper handling of all resident financial records. Executive Director or designee will complete. Completion date will be 1/6/2026.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (- 01/23/2026)

Resident Privacy Coding *(continued)*

Resident 1	*Judy Wieland*
Resident 2	*Carolyn Myers*
Resident 3	*Barbara Wachter*
Resident 4	*Michael Tokar*
Resident 5	*Arlene Smith*
Resident 6	*Guy Grubel*
Resident 7	*Constance Citrolla*
Resident 8	*Daniel Trythall*
Resident 9	*Robert Weitzman*
Resident 10	*Miranda Linne*
Resident 11	*Robert Drozdowski*
Resident 12	*Deborah Serentsis*
Resident 13	*Leonard Sterner*
Resident 14	*Elizabeth Hate*
Resident 15	*Anne Rosario*
Resident 16	*Mary Nagel*
Resident 17	*Cathy Ann Stout*
Resident 18	*John Wagner*
Resident 19	*Helen Rohrbach*
Resident 20	*Robert Hornberger*
Resident 21	*Francis Margavich*