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

January 2, 2026

KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC

RE: SPRING MILL SENIOR LIVING
3000 BALFOUR CIRCLE
PHOENIXVILLE, PA, 19460
LICENSE/COC#: 14632

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/04/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SPRING MILL SENIOR LIVING* **License #**: *14632* **License Expiration**: *05/05/2026*

Address: *3000 BALFOUR CIRCLE, PHOENIXVILLE, PA 19460*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *09/10/2009* **Issued By**: *East Pikeland Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *114* **Waking Staff**: *86*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *11/04/2025*

Inspection Dates and Department Representative

11/04/2025 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98* **Residents Served**: *89*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *22* **Residents Served**: *16*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *85*

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

Have Mobility Need: *25* **Have Physical Disability**: *0*

Inspections / Reviews

11/04/2025 Partial

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

12/04/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/23/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/23/2025*

Inspections / Reviews *(continued)*

01/02/2026 Document Submission

Submitted By: [redacted]
Date Submitted: *12/23/2025*
Reviewer: [redacted]
Follow Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], Staff person A alleged that they witnessed staff person B shouting and cursing at residents and neglected to provide incontinence care on multiple occasions. However, this allegation of abuse was not reported to the local area agency on aging until [redacted]

Repeat Violation Date: [redacted]

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

- The Executive Director provided a mandatory in-service training on mandated reporting to the community team October 29, 2025, ensuring that all staff are aware of their reporting responsibilities.
- An additional in-service session on reporting is scheduled for November 25, 2025, to provide further training and support.
- The Executive Director retrained the Memory Care Director and the Director of Health and Wellness to ensure proper follow-up on resident notes by running random reports weekly. This initiative will help identify issues that need to be addressed with primary care providers starting on November 13, 2025.
- The Executive Director initiated monthly audits of incident reports and compliance documentation beginning on October 8, 2025. After the first three months, these audits will transition to a quarterly schedule to ensure ongoing compliance and accountability.
- A behavior tracking form will be developed by November 26, 2025, to alert leadership to issues as they occur. This form will be reviewed during the daily clinical morning meetings, along with all incident reports, to ensure timely awareness and response to any concerns.
- The Executive Director will be responsible for the effective implementation of this plan, which aims to enhance the safety and well-being of residents. All documentation related to audits and training sessions will be maintained to ensure compliance with regulations and facilitate reviews.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

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

Implemented [redacted] - 01/02/2026)

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

On [redacted] Staff person A alleged that they witnessed staff person B shouting and cursing at residents and neglected to provide incontinence care on multiple occasions.
The home did not report this incident to the department until [redacted]

Repeat Violation Date: [redacted]

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

- The Executive Director provided a mandatory in-service training on mandated reporting to the community team October 29, 2025, ensuring that all staff are aware of their reporting responsibilities.
- An additional in-service session on reporting is scheduled for November 25, 2025, to provide further training and support.
- The Executive Director retrained the Memory Care Director and the Director of Health and Wellness to ensure proper follow-up on resident notes by running random reports weekly. This initiative will help identify issues that need to be addressed with primary care providers starting on November 13, 2025.
- The Executive Director initiated monthly audits of incident reports and compliance documentation beginning on October 8, 2025. After the first three months, these audits will transition to a quarterly schedule to ensure ongoing compliance and accountability.
- A behavior tracking form will be developed by November 26, 2025, to alert leadership to issues as they occur. This form will be reviewed during the daily clinical morning meetings, along with all incident reports, to ensure timely awareness and response to any concerns.
- The Executive Director will be responsible for the effective implementation of this plan, which aims to enhance the safety and well-being of residents. All documentation related to audits and training sessions will be maintained to ensure compliance with regulations and facilitate reviews.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

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

16c Written Incident Report *(continued)*

Implemented (- 01/02/2026)

17 Record Confidentiality

3. Requirements

2600.

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

Description of Violation

On at approximately 5:00 PM, Resident records were unlocked, unattended, and accessible in the Healthcare med suite on the 2nd floor.

Repeat Violation Date: et al.

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

- The primary cause of the violation was identified as the failure of the keypad due to dead batteries.

- The batteries for the keypad were replaced immediately following the state findings to restore secure access to the Healthcare med suite.

- A checklist has been created to ensure compliance with confidentiality regulations. This checklist will include steps to verify that resident records are secured at all times.

- Members of the leadership team will conduct random walkthroughs during all shifts to ensure that the nurse's station is secured and confidential information is not left unattended in common areas. Documentation of these walkthroughs will be maintained for accountability.

- A training session was conducted on November 25, 2025, to educate staff on the importance of resident record confidentiality and proper handling procedures.

- The Director of Facilities will perform weekly inspections for the next three months, transitioning to monthly inspections thereafter. Documentation of these inspections will be maintained the maintenance electronic system.

- The Executive Director will be responsible for the effective implementation of this plan, which aims to enhance the safety and well-being of residents. All documentation related to audits and training sessions will be maintained to ensure compliance with regulations and facilitate reviews.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

17 Record Confidentiality *(continued)*

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

Implemented - 01/02/2026)

23a - Activities of Daily Living Assistance

4. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated , for resident indicates the resident requires assistance with moderate supervision in and out of the home due to wandering. On at 7:02PM, the resident did not receive this assistance as required and was able to leave home unsupervised and wander a distance of 1.5 miles away. Resident from the SDCU on sometime after 9:45pm to the patio area of the personal care portion of the home. Resident was found around 11pm. Resident s RASP dated indicates the resident requires supervision and cannot leave the home without the staff or family.

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

The assessment and support plans for both Resident and Resident were reviewed with the Memory Care Director and the Director of Health and Wellness on November 5, 2025, to ensure they understood the importance of following the plans closely.

A staff meeting was conducted on November 25, 2025, to address the violations and reinforce the importance of adhering to residents' assessment and support plans.

A protocol for team members to follow the residents' support plans will be added to our electronic health system. This integration will help with ensuring all team members have access to up to date support plans, improving coordination and consistency in care, provide a clear framework for staff to follow and minimizing the risk of oversight and ensuring adherence to resident needs.

The Assistant Director of Health and Wellness and the Health Care Coordinators will conduct weekly audits for the next three months to ensure compliance with resident assessments and support plans. This will include reviewing staff adherence to supervision protocols and documenting any incidents of non compliance. After three months, audits will transition to every six months.

The Executive Director will monitor for compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

23a - Activities of Daily Living Assistance *(continued)*

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

Implemented [redacted] - 01/02/2026)

25b - Contract Signatures

5. Requirements

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

Description of Violation

The resident-home contract, dated [redacted], for resident [redacted] was not signed by the resident.
The resident-home contract, dated [redacted], for resident [redacted] was not signed by the resident.

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

- The contracts for Resident [redacted] and Resident [redacted] have been reviewed, and efforts are being made to obtain the necessary signatures retroactively.
- On November 25, 2025, a training session was conducted for the administration and staff responsible for the completion of resident contracts. This training emphasized the importance of ensuring that all necessary signatures are obtained on contracts prior to the resident's admission.
- The admission checklist has been updated to ensure that the resident's signature is obtained prior to the move-in date. This process has been established to ensure that all resident-home contracts are checked for completeness, including signatures from the resident, administrator, payer, and designated person (if applicable), before they are finalized. The Sales Associate will be responsible for ensuring that the checklist is completed in a timely manner and prior to the contract signing. Additionally, the Executive Director will ensure that this is completed by the time the contract is signed.
- The Business Office Director will conduct regular audits of resident records to confirm that all documentation is complete and compliant.
- The Executive Director will monitor for compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

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

Implemented [redacted] - 12/29/2025)

41e - Signed Statement

6. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident and resident 's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

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

- On November 25, 2025, the Executive Director conducted a training session for Residents and ensuring they were informed of their rights and the complaint procedures. During this session, signed statements acknowledging receipt of the information were obtained and documented in their records. To prevent this violation from reoccurring, we have updated the admission checklist to ensure that residents' rights and complaints procedures are reviewed during the admission process. The Sales Associate will be responsible for ensuring that the checklist is completed in a timely manner and prior to the contract signing. Additionally, the Executive Director will ensure that this is finalized by the time the contract is signed.
- On November 26, 2025, the Executive Director retrained the Director of Health and Wellness and the Business
- The Business Office Director will conduct regular audits of resident records to confirm that all documentation is complete and compliant.
- The Executive Director will monitor for compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

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

Implemented - 12/29/2025)

42b - Abuse

7. Requirements

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

Description of Violation

The assessment and support plan, dated for resident indicates the resident requires assistance with moderate supervision in and out of the home due to wandering. On resident from the home sometime after 5:30pm when the resident was last seen while eating dinner. At approximately 7:00PM, the home received a call from a police officer reporting that resident was located outside of the home, initially at a private local residence. Resident was then driven to local pizza shop and dropped off there by an unknown person who was

42b - Abuse (continued)

present at the private residence. The police were contacted, and the resident was escorted back to the home around 8:00PM. Resident also wears a Wander Guard while in the home, which is designed to engage the magnetic locks on the door when the system senses a Wander Guard device nearby to prevent elopement. However, on , the Wander Guard system did not function properly, which allowed the resident to exit the home through the main doors.

Resident from the SDCU on sometime after 9:45pm to the patio area of the personal care portion of the home. Resident was found around 11pm. Resident RASP dated indicates the resident requires supervision and cannot leave the home without the staff or family. It was determined that Resident was able to leave the SDCU area through an unlocked door that led into a kitchen area which is connected to the unsecured personal care area of the home. The door to the kitchen is typically locked with a key to prevent SDCU residents from entering the kitchen area, however on it was discovered that the key to the door was still in the lock and resident was able to open the door and enter the kitchen unnoticed.

Repeat Violation Date:

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

- An additional in-service training session was conducted by the Executive Director for the leadership team and nursing staff on November 13, 2025. This session emphasized the importance of adhering to resident support plans, proper supervision protocols, and the significance of functionality checks for safety equipment like the Wander Guard system.
- The Memory Care Director and the Director of Health and Wellness will be jointly responsible for overseeing the implementation of a supervision protocol. This includes conducting regular checks to ensure that all doors leading to unsecured areas are locked and that residents who need supervision are monitored closely. Nursing staff was trained on these protocols on October 29 and 11/13/2025. Accountability measures will be established.
- Compliance with the supervision protocols and safety measures will be reviewed with the leadership team during our weekly clinical meetings. This will ensure ongoing awareness and a collective responsibility for resident safety.
- A behavior tracking form will be developed by November 26, 2025, to identify and document any incidents or concerns related to resident safety as they occur. This form will be reviewed during daily clinical morning meetings alongside all incident reports to facilitate timely responses to concerns.
- The Executive Director will conduct sporadic audits of safety procedures and staff documentation for the next three months. Following this period, the audits will transition to random audits effective November 26, 2025. These audits will focus on identifying any safety issues, ensuring compliance with protocols, and determining the need for additional training.
- A maintenance schedule has been established for the Wander Guard system and other safety equipment to ensure their functionality. The Director of Facility and the Director of Health and Wellness have been trained on how to conduct regular checks and promptly report any malfunctions. The Executive Director will perform monthly checks of the Wander Guard system for the next three months, transitioning to quarterly checks thereafter to enhance oversight and ensure compliance. Documentation of these checks by both the Director of Facilities and the Executive Director will be maintained in our maintenance system.
- The Executive Director will monitor for compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are

42b Abuse (continued)

correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

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

Implemented (- 01/02/2026)

95 - Furniture and Equipment

8. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

Resident wander guard was not functioning appropriately on at approximately 7:00pm. The wander guard did not alert or lock the main front door as it should have, allowing the resident to wander outside and away from the facility without the staff's knowledge.

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

The malfunctioning Wander Guard was replaced immediately following the incident to ensure resident safety.
A walkthrough was conducted after the incident to identify issues and ensure that all safety equipment in the community was in good repair.
All Wander Guard systems were tested following the incident to ensure they were operational and effective.
The Director of Facilities will conduct monthly walkthroughs of safety equipment, and documentation of these walkthroughs will be maintained.
The Executive Director provided immediate training to the Memory Care Director and the Director of Health and Wellness after the incident to reinforce the importance of regular equipment checks and proper procedures.
A maintenance schedule has been established for the Wander Guard system and other safety equipment to ensure their functionality. The Director of Facility and the Director of Health and Wellness have been trained on how to conduct regular checks and promptly report any malfunctions. The Executive Director will perform monthly checks of the Wander Guard system for the next three months, transitioning to quarterly checks thereafter to enhance oversight and ensure compliance. Documentation of these checks by both the Director of Facilities and the Executive Director will be maintained in our maintenance system.
The Executive Director will monitor for compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent

95 - Furniture and Equipment (continued)

remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

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

Implemented [redacted] - 01/02/2026)

187d - Follow Prescriber's Orders

9. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted] 1 tablet by mouth every night at 9pm. However, on [redacted] and [redacted], there was no documentation to indicate medication was administered to resident [redacted].
Resident [redacted] has an order for wound care to [redacted] open area to cleanse with saline, apply TAO, cover with non-stick dressing. Ordered to be done daily at 8am. However, on [redacted] and [redacted] resident did not receive wound care as ordered.

Repeat Violation Date: [redacted] et al.

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

- A meeting was held on 11/13/2025 to discuss the violations and regulatory requirements with medication administrators and the leadership team.
- A comprehensive medication training for all nurses and med techs, regardless of certification status, scheduled for 12/13/2025 with a designated med trainer.
- The Director of Health and Wellness and the Health Care Coordinators will conduct Medication Administration Record audits daily for the next 4 weeks. After 4 weeks, the audits will transition to once a week for the next 3 months to ensure compliance and identify any ongoing issues. These audits will also include a med tech-to-med tech shift count of controlled substances.
- The Director of Health and Wellness will conduct regular check-ins with the staff to address any challenges and provide additional support or training as needed.
- A Medication Availability Checklist has been developed to be completed weekly by nursing staff to ensure that all prescribed medications are on hand. This checklist will be implemented on December 5, 2025, following the training scheduled with the Director of Health and Wellness, health care coordinators, and med techs. The training will be provided by the Executive Director.
- The Executive Director will monitor the implementation of this plan for compliance, reviewing audit results and staff feedback regularly.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors'

187d - Follow Prescriber's Orders (continued)

findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

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

Implemented - 01/02/2026)

191 - Resident Right to Refuse

10. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident , admitted and Resident , admitted have not been educated to the residents' right to refuse medication if the residents believe that there may be a medication error.

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

- On November 25, 2025, the Executive Director conducted a training session for Residents and ensuring they were informed of their rights regarding medication refusal and the procedures to follow if they believe there may be a medication error. Signed statements acknowledging receipt of this information were obtained and documented in their records.
- On November 26, 2025, the Executive Director retrained the Director of Health and Wellness to reinforce the importance of educating residents about their rights and to ensure that this information is communicated effectively during medication administration.
- The admission checklist has been updated to ensure that all residents receive education on their rights regarding medication and that signed acknowledgments are maintained in their records. This process will guarantee that residents are aware of their rights prior to their move-in date.
- The Business Office Director will conduct regular audits of resident records to confirm that all documentation related to resident education is complete and compliant with regulatory requirements.
- The Executive Director will monitor compliance with the resident education requirements and ensure that staff members understand and implement the training as part of their routine practices.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this

191 - Resident Right to Refuse (continued)

plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

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

Implemented [redacted] - 12/29/2025)

225c - Additional Assessment

11. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [redacted] current assessment was completed on [redacted]. However, the resident's previous assessment was completed on [redacted]

Repeat Violation Date: [redacted] et al.

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

- A meeting was held on 11/13/2025 to discuss the violations and regulatory requirements with the nursing team and the leadership team.
- Resident 1's assessment and support plan was updated on November 17, 2025, to include specific positive interventions tailored to address aggressive behaviors and 1:1 staff supervision.
- The Executive Director provided training to the Memory Care Director and the Director of Health and Wellness on November 13, 2025, emphasizing the critical importance of routinely reviewing support plans to ensure that they accurately reflect the evolving needs of residents. To ensure compliance and effectively monitor the needs of our residents, we will implement a quarterly audit schedule. The Memory Care Director will conduct quarterly assessments for the residents in memory care every January, April, July, and October. The Director of Health and Wellness will perform quarterly reviews for the residents in personal care during the same months.
- A process will be established to monitor and track condition changes that require updates to resident assessments and support plans. This will include regular assessments by nursing staff, a standardized form for documenting changes in behavior or health status, and a protocol for reporting significant changes to the Director of Health and Wellness.
- Regular review meetings will also be held to evaluate these documented changes and determine necessary updates to support plans.
- The Executive Director will monitor for compliance.

This plan of correction is submitted as required under State and/or Federal law. The submission of this plan of correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are

225c Additional Assessment (continued)

correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

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

Implemented - 01/02/2026)

231c - Preadmission Screening

12. Requirements

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

Description of Violation

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

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

The root cause analysis determined that the cognitive preadmission screening was not completed on time due to an oversight resulting from an emergency move in to the memory care unit. This move was necessary to ensure the resident's safety and prevent another elopement.

The cognitive preadmission screening for Resident was completed on November 5, 2025, and documented in the resident's record.

A comprehensive audit of all resident records is being conducted to ensure compliance with cognitive preadmission screening requirements. This audit will help identify any additional documentation gaps and will be performed quarterly.

The admission checklist has been reviewed to ensure that all required documentation, including cognitive preadmission screenings, is completed as soon as feasible during emergency admissions. This checklist will also be utilized during internal moves to ensure consistency and adherence to documentation requirements.

The Executive Director will review the results of the audits and the effectiveness of the new admission procedures on a quarterly basis to ensure ongoing compliance and to address any further issues that may arise.

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231c Preadmission Screening *(continued)*

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

Implemented (█ - 12/29/2025)

233d - Electronic/Magnetic System

13. Requirements

2600.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

On █, the door that leads from the secured unit into the kitchen area and on to the unsecured personal care area of the home, was not locked with an electronic or magnetic locking system. The door was equipped with a key locking device. On █ it was determined that a key had been left in the lock, allowing resident █, who resided in the SDCU, to open the door, enter the kitchen and exit the building to a patio in the personal care area of the home.

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

The door mechanism was changed to one that does not require a key, ensuring it is now secured with an electronic or magnetic locking system that complies with regulatory requirements.

Staff members were retrained on the importance of securing all entry points to the secured unit and the proper use of the new locking system. Staff were specifically instructed to avoid leaving keys in locks, to perform regular checks to ensure doors are properly secured, and to report any security breaches or concerns regarding door locks immediately. This will ensure that any issues are addressed promptly.

Bi weekly audits of all doors leading from secured areas to unsecured areas will be conducted for the next three months. This will include checking for the functionality of locking mechanisms and ensuring that no keys are left in locks.

The Executive Director will monitor for compliance.

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

Implemented (█ - 01/02/2026)

252 - Record Content

14. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident [redacted] record does not include color of hair, color of eyes, and identifying marks, a photograph of the resident that is no more than 2 years old.
Resident [redacted] record does not include a photograph of the resident that is no more than 2 years old.

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

- The root cause was identified as a procedural oversight in the documentation process regarding the inclusion of current photographs and personal identifying information in resident records.
- On November 13, 2025, the Executive Director conducted training for the Memory Care Director and the Director of Health and Wellness on the importance of maintaining accurate and up-to-date resident records, including the requirement for photographs taken within the last two years and all the additional information. This training emphasized adherence to regulatory standards and the significance of accurate documentation in resident care.
- A photograph of Resident 2 was taken, and the missing information regarding hair color, eye color, and

252 - Record Content (continued)

identifying marks was added to the resident's record immediately after the state inspection. Similarly, a photograph of Resident 3 was taken to meet the documentation requirement.
- An audit of Resident 2 and Resident 3's records has been conducted to identify any missing information. The residents' records have been reviewed to ensure they are in compliance with the regulations.
- The Memory Care Director and Director of Health and Wellness will be responsible for conducting quarterly audits of resident records every January, April, July, and October. These audits will specifically check for the inclusion of current photographs and compliance with documentation requirements.
- During the morning clinical meeting, the Executive Director, Director of Health and Wellness, and the Memory Care Director will review new admission documentation and assessment requirements to ensure timeliness and compliance. This review will help us identify any potential delays and implement necessary improvements to streamline the admission process.
- The Executive Director will review the auditing process and findings on a quarterly basis to ensure ongoing compliance and to address any further issues that may arise regarding resident documentation.

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

Implemented [redacted] 01/02/2026)