pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SYCAMORE ESTATES, LLC**
LEGAL ENTITY

To operate **SYCAMORE ESTATE PERSONAL CARE RESIDENCE**
NAME OF FACILITY OR AGENCY

Located at **717 DUQUESNE BLVD, DUQUESNE, PA 15110**
(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 **49**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions:

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

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

and shall remain in effect from **December 17, 2025** until **June 17, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454501**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 17, 2025

[redacted]
Sycamore Estates, LLC
717 Duquesne Blvd.
Duquesne, Pennsylvania 15110

RE: Sycamore Estate Personal Care Residence
License #: 454501

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on September 25, 2025, and November 6, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 454500) dated December 17, 2025 – December 17, 2026, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from DECEMBER 17, 2025 to JUNE 17, 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)
187(d)	III	26	$3	$ 78	15 calendar days from mailing date of this letter

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

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

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

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

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *SYCAMORE ESTATE PERSONAL CARE RESIDENCE* **License #:** *45450* **License Expiration:** *12/17/2025*

Address: *717 DUQUESNE BLVD, DUQUESNE, PA 15110*

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

Administrator

Name: [redacted]

Legal Entity

Name: *SYCAMORE ESTATES, LLC*

Address: *717 DUQUESNE BLVD, DUQUESNE, PA, 15110*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *05/14/1999* **Issued By:** *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *34* **Waking Staff:** *26*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *09/25/2025*

Inspection Dates and Department Representative

09/25/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *49* **Residents Served:** *27*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *5* **Are 60 Years of Age or Older:** *27*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *7* **Have Physical Disability:** *0*

Inspections / Reviews

09/25/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/11/2025*

Inspections / Reviews *(continued)*

10/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/31/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/17/2025*

10/20/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/31/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/01/2025*

12/03/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/31/2025*

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

25c4 - Payment Responsibility

1. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
4. The party responsible for payment.

Description of Violation

The resident-home contract, dated [redacted]/24, for resident #1 does not specify the party responsible for payment.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

The resident-home contract for resident #1 was corrected on 10/14/2025 to specify the party responsible for payment, and a copy was provided to the resident. The Administrator has updated the contract template to include a designated section for payment responsibility and is now using the new version for all admissions, see attached. An audit of all current resident contracts will be conducted by the Administrator beginning 10/15/2025 and completed by 10/31/2025 to ensure accuracy and completeness. Going forward, the administrator, or designee, will perform monthly spot checks of 10% of contracts under the Administrator's supervision to maintain ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented [redacted] - 12/03/2025)

25c12 - Bed Hold

2. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
12. Charges to the resident for holding a bed during hospitalization or other extended absence from the home.

Description of Violation

The resident-home contract , dated [redacted]/24, for resident #1 does not include the charges for holding a bed during an absence.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

The resident-home contract for resident #1 was corrected on 10/14/2025 to specify the bed hold fee, and a copy was provided to the resident. An audit of all current resident contracts will be conducted by the Administrator beginning 10/15/2025 and completed by 10/31/2025 to ensure accuracy and completeness. Going forward, the administrator, or designee, will perform monthly spot checks of 10% of contracts under the Administrator's supervision to maintain ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented [redacted] - 12/03/2025)

63a - First Aid/CPR Training

3. 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.

63a - First Aid/CPR Training *(continued)*

Description of Violation

On 9/14/25 from 11:00 p.m. until 11:59 p.m. there were 27 residents present in the home. During this time, direct care staff person A and direct care staff person B were the only aides in the home and direct care staff person B was not trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) and direct care staff person A's training and certification in obstructed airway techniques and CPR expired in August of 2025.

On 9/15/25 from 12:00 a.m. until 7:00 a.m. there were 27 residents present in the home. During this time, direct care staff person A and direct care staff person B were the only aides in the home and direct care staff person B was not trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation (CPR) and direct care staff person A's training and certification in obstructed airway techniques and CPR expired in August of 2025.

REPEAT VIOLATION 8/27/24 et. al.

Plan of Correction ***Accept [redacted]K - 10/14/2025)***

The resident care coordinator (RCC) has reviewed the schedule on 10/1/25 and confirmed there is at least one staff person for every 50 residents trained in first aid and certified in obstructed airway techniques and CPR. The RCC will review the schedule every week and approve call-off/schedule changes to ensure compliance. CPR training for the facility took place in August 2025 and there will be another CPR training course scheduled in November to continue to ensure all new employees have updated certifications.

Licensee's Proposed Overall Completion Date: *10/07/2025*

Implemented [redacted] - 12/03/2025)

65i - Training Record

4. 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

There was no record of the annual staff training completed by ancillary staff person C for the calendar year 2024 to include:

(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.

(2) Emergency preparedness procedures and recognition and response to crises and emergency situations.

(3) Resident rights.

(4) The Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102).

(5) Falls and accident prevention.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

Staff person C will be trained on the topics noted in the violation by 10/25. An audit of all current staff records to ensure all staff persons have completed the required education and the documentation is in accordance with Regulation 2600/65(i) will be completed by the administrator or designee by 10/31/25, see template. Going forward and audit of staff training will be completed quarterly by the administrator or designee.

Licensee's Proposed Overall Completion Date: *10/31/2025*

65i - Training Record *(continued)*

Implemented [redacted] - 12/03/2025)

66b - Training Plan Content

5. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan for 2025 was incomplete and did not include the projected date and time of each required training topic.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

The Administrator will review and amend the 2025 training plan for the year to include the projected date and time of each required training topic and on a 12-month rolling basis. The staff training plan will be reviewed monthly at the monthly in-service staff meeting to ensure the staff training plan includes the dates, times and locations of the scheduled training for each staff person. This audit will begin at the October in-service meeting by 10/31/25 by the administrator or designee.

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented [redacted] - 12/03/2025)

85d - Trash Receptacles

6. Requirements

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

Description of Violation

At approximately 11:47 a.m., the garbage can in the shared full bathroom designated Bath F in the North Up section of the home was uncovered and there was no lid.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

During the time of inspection, the garbage can in shared full bathroom designated Bath F in the North Up section of the home was replaced by a garbage can with a functioning lid. All current employees will be trained on this requirement at the in-service meeting on 10//29/25 by the administrator. Moving forward, this requirement will be included in the day-1 orientation training for all new employees alongside 65(a) and (b). The administrator or designee will conduct a weekly walk through audit of the facility to ensure compliance with physical plant requirements, see attached. This audit will begin the week of 10/20/25 and will be kept in the facility's maintenance log book.

Licensee's Proposed Overall Completion Date: *10/29/2025*

Implemented [redacted] - 12/03/2025)

91 - Telephone Numbers

7. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

At approximately 12:01 p.m. the emergency telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline were not posted on or near the telephone located on the desk behind the countertop in front of the medication room.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

During the time of inspection the emergency phone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline were posted by the telephone located on the desk by the medication room. On 10/3/25, the emergency numbers were added to each resident room. This regulation has been included in day 1 training 65(a) for "Telephone use and notification of emergency services." and an audit for all employees will be completed by 10/31/25. All employees will be retrained on the October in-service meeting on 10/29/25 by the administrator and documentation will be kept in accordance with Regulation 2600.65(i). The administrator or designee will perform a weekly walk through of the facility to audit the placement of the emergency phone numbers at all phone locations in the home starting the week of 10/20/25.

Licensee's Proposed Overall Completion Date: *10/29/2025*

Implemented [redacted] - 12/03/2025)

103i - Outdated Food

8. Requirements

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

Description of Violation

At approximately 11:01 a.m. in the upper right hand side of the home's basement TRUE upright two-door cooler, there were two cantaloupes that were soft and were coated in a grey substance that appeared to be mold. Additionally, there were two honeydews in the same area of the cooler behind the cantaloupes with soft black spots that appeared to be mold or rot.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

The moldy food was removed during the inspection. A full audit of the food storage area was completed 10/1/25. A daily audit will be completed by kitchen staff during the cooler temp recording to ensure any food that has spoiled is promptly removed and staff will be trained on this at the next in-service meeting by the administrator or kitchen manager on 10/29/25 and training record kept in accordance with regulation 2600.65(i). All future kitchen staff will be trained as a part of day 1 orientation for training and records kept in accordance with 2600.65(i). The administrator or designee will perform a weekly walk through of the facility to audit that all food storage areas are kept in good order and in accordance with 2600.103.i. starting the week of 10/20/25.

Proposed Overall Completion Date: 10/29/2025

Licensee's Proposed Overall Completion Date: *10/29/2025*

Implemented [redacted] - 12/03/2025)

132b - Safety Inspection/Fire Drill

9. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's most recent fire safety inspection and supervised fire drill conducted by a fire safety expert was held on 4/11/24.

Plan of Correction ***Directed [redacted] - 10/20/2025)***

The City of Duquesne fire chief was notified on the day of the inspection to have a fire drill completed under [redacted] supervision. The October fire drill will be conducted under [redacted] super vision by 10/31 and [redacted] will complete a fire inspection. The fire drill policy was updated to include language requiring the annual inspection by a fire safety expert see attached. August is Fire Safety at Sycamore Estates and this will be annually scheduled in-line with the annual review of the fire safety system at the facility.

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Within one day of the receipt of the plan of correction: The administrator shall include the requirements of Regulation 2600.132(b) as part of the quality management review process to ensure a fire inspection and a fire drill shall be conducted in accordance with Regulation 2600.132(b). Documentation shall be kept. [redacted] 10/20/25

Directed Completion Date: *10/31/2025*

Implemented [redacted] - 12/03/2025)

132c - Fire Drill Records

10. 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

On 8/29/24 at 10:05 a.m. the home conducted a fire drill; however, the home's fire drill record did not record the exit route used.

On 9/24/24 at 2:10 p.m. the home conducted a fire drill; however, the home's fire drill record did not record the exit route used.

On 5/12/25 at 4:37 a.m., the home conducted a fire drill; however, the home's fire drill record did not record the time to evacuate in minutes and seconds and only indicated the minutes.

Plan of Correction ***Directed [redacted] - 10/20/2025)***

The administrator has created the attached procedure to guide staff in the execution and proper recording of a fire drill including the requirement to rotate exits and record the time using minutes and seconds. This has been included in the fire drill log book and will guide the next fire drill to occur prior to 10/31/25. All staff members will be

132c - Fire Drill Records (continued)

retrained on the requirements of a fire drill as part of 65.a at the next in-service on 10/29/25 by the administrator and the training record kept in accordance with 2600.65.(i). Since in-service meetings are held at the end of the month, this will also serve as the quality audit to ensure compliance with the internal policy by the administrator or designee. All logs will be kept in the fire drill log book as per the requirements of 2600.

Proposed Overall Completion Date: 10/29/2025

DIRECTED
Within one day of the receipt of the plan of correction: The administrator shall audit the home's fire drill record monthly to ensure the requirements of Regulation 2600.132(c) are [redacted] 10/20/25

Directed Completion Date: *10/29/2025*

Implemented[redacted] - 12/03/2025)

132d - Evacuation

11. 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

On 4/30/25 at 4:08 p.m. the home conducted a fire drill with an evacuation time of 4 minutes and 6 seconds. However, there was no maximum safe evacuation time documented in writing by a fire safety expert and the default time was 2 minutes and 30 seconds.

On 5/12/25 at 4:37 a.m. the home conducted a fire drill with an evacuation time of 5 minutes and seconds were not indicated. However, there was no maximum safe evacuation time documented in writing by a fire safety expert and the default time was 2 minutes and 30 seconds.

On 6/30/25 at 1:57 p.m. the home conducted a fire drill with an evacuation time of 4 minutes and 22 seconds. However, there was no maximum safe evacuation time documented in writing by a fire safety expert and the default time was 2 minutes and 30 seconds.

On 7/18/25 at 3:27 p.m. the home conducted a fire drill with an evacuation time of 4 minutes and 35 seconds. However, there was no maximum safe evacuation time documented in writing by a fire safety expert and the default time was 2 minutes and 30 seconds.

On 8/22/25 at 1:25 p.m. the home conducted a fire drill with an evacuation time of 3 minutes and 36 seconds. However, there was no maximum safe evacuation time documented in writing by a fire safety expert and the default time was 2 minutes and 30 seconds.

Plan of Correction ***Directed[redacted]K - 10/20/2025)***

The last fire safety expert specification for maximum time for evacuation was in April 2024 which referenced a maximum safe time previously measured in previous years. The fire safety expert has been contacted and will be

132d - Evacuation (continued)

on site to conduct a safety evaluation and confirm the maximum safe time for evacuation is 5min by October 31. The administrator or designee shall audit the fire drill record monthly to ensure an unannounced fire drill shall be held at least once a month to ensure residents are evacuated from 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.

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Within one day of the receipt of the plan of correction: The administrator or designee shall audit the fire drill record monthly to ensure an unannounced fire drill shall be held at least once a month to ensure residents are evacuated from 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. [redacted] *10/20/25*

Within one day or receipt of the plan of correction: The administrator shall complete the following steps to reduce the safe evacuation to a time less than 2 minutes and 30 seconds, or a fire safe evacuation time specified by a fire safety expert.
• Request a decrease in licensed capacity and discharge residents.
• Provide resident and staff education on evacuation policies and procedures. Documentation will be kept.
• Conduct additional fire drills.
• Relocate residents who require special assistance with evacuation closer to exits or fire-safe areas.
• Add additional staff (at all times) to meet the 2 minute and 30 second evacuation time or the safe evacuation time specified by the fire safety expert within the past year.
[redacted] *10/20/25*

Directed Completion Date: *10/31/2025* Not Implemented [redacted] - 12/03/2025)

132e - Fire Drill Sleeping Hours

12. Requirements

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

Description of Violation

The home's most recent sleeping hours fire drill was completed on 5/12/25 at 4:37 a.m., however, there was no sleeping hours fire drill conducted in the six-months prior to the current drill, and the most recent prior sleeping hours drill was conducted on 5/29/24 at 6:15 a.m.

Plan of Correction ***Directed ([redacted] - 10/20/2025)***

The administrator has created the attached procedure to guide staff in the execution and proper recording of a fire drill including the requirement to rotate exits and record the time using minutes and seconds. This has been included in the fire drill log book and will guide the next fire drill to occur prior to 10/31/25. All staff members will be retrained on the requirements of a fire drill as part of 65.a at the next in-service on 10/29/25 by the administrator and the training record kept in accordance with 2600.65.(i). Since in-service meetings are held at the end of the month, this will also serve as the quality audit to ensure compliance with the internal policy by the administrator or designee. All logs will be kept in the fire drill log book as per the requirements of 2600. The administrator or

132e - Fire Drill Sleeping Hours (continued)

designee shall audit the fire drill record monthly to ensure a fire drill shall be held during sleeping hours once every 6 months.

Proposed Overall Completion Date: 10/29/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator or designee shall audit the fire drill record monthly to ensure an fire drill shall be held during sleeping hours once every 6 months. [redacted] *10/20/25*

Directed Completion Date: *10/29/2025*

Not Implemented [redacted] - 12/03/2025)

132f - Alternate Exit Routes

13. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

Exit route "Main" was the only exit route used for evacuation during fire drills held on dates to include:

- *7/31/24*
- *10/2/24*
- *11/20/24*
- *12/18/24*
- *1/31/25*

Plan of Correction ***Directed*** [redacted] ***- 10/20/2025)***

The administrator has created the attached procedure to guide staff in the execution and proper recording of a fire drill including the requirement to rotate exits. This has been included in the fire drill log book and will guide the next fire drill to occur prior to 10/31/25. All staff members will be retrained on the requirements of a fire drill as part of 65.a at the next in-service on 10/29/25 by the administrator and the training record kept in accordance with 2600.65.(i). Since in-service meetings are held at the end of the month, this will also serve as the quality audit to ensure compliance with the internal policy by the administrator or designee. All logs will be kept in the fire drill log book as per the requirements of 2600. The administrator or designee shall audit the fire drill record monthly to ensure a fire drill shall be held during sleeping hours once every 6 months.

Proposed Overall Completion Date: 10/29/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator or designee shall audit the fire drill record monthly to ensure alternate exit routes shall be used during fire drills. [redacted] *10/20/25*

Directed Completion Date: *10/29/2025*

Implemented [redacted] ***- 12/03/2025)***

141a 1-10 Medical Evaluation Information

14. Requirements

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

Description of Violation

Resident #2's medical evaluation, dated [redacted]/25, did not indicate the resident's weight, temperature, and whether the resident's needs could be met in the personal care home, those areas of the form were left blank.

Resident #3's medical evaluation, dated [redacted]/25, did not indicate the resident's weight, temperature, and whether the resident's needs could be met in the personal care home, those areas of the form were left blank.

Plan of Correction ***Directed [redacted] - 10/20/2025)***

Resident #2 and #3 DMEs were updated to include the biometrics of each respective resident. The administrator or designee will audit all DMEs by 10/31 to ensure completion or they will be completed by the house attending physician. The Resident Care Coordinator (RCC) will be trained on requirement for completion of DME biometrics by the administrator on or before 10/31 to ensure compliance for future DME submissions. Training will be given by the administrator and recorded per 2600.65(i).

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall audit all newly completed medical evaluation document to ensure accuracy and completeness, [redacted] 10/20/25

Directed Completion Date: *10/31/2025* Not Implemented [redacted] - 12/03/2025)

141b1 - Annual Medical Evaluation

15. Requirements

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

Description of Violation

Resident #1's most recent medical evaluation, signed by medical provider on 9/5/25, did not indicate whether it was an initial, annual, or a status change medical evaluation, the date of in person evaluation or date the form was completed, the resident's weight, advanced directives status, allergies, immunization history, body positioning/movement, health status, cognitive functioning, and whether the resident's needs could be met in the personal care home, those areas of the form were left blank.

Resident #4's most recent medical evaluation, dated [redacted]/25, did not include the resident's weight, pulse rate, blood

141b1 - Annual Medical Evaluation (continued)

pressure, temperature, special health/dietary needs, immunization history, health status, and cognitive functioning, those areas of the form were left blank.

Plan of Correction ***Directed [redacted] - 10/20/2025)***

Resident #1 and #4 DMEs were updated for completion. The administrator or designee will audit all DMEs by 10/31 to ensure completion or they will be completed by the house attending physician. The Resident Care Coordinator (RCC) will be trained on requirement for completion of DME biometrics by the administrator on or before 10/31 to ensure compliance for future DME submissions. Training will be given by the administrator and recorded per 2600.65(i).

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator shall audit all newly completed medical evaluation document to ensure accuracy and completeness, [redacted] 10/20/25

Directed Completion Date: *10/31/2025*

Not Implemented [redacted] - 12/03/2025)

162c - Menus Posted

16. 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's posted menus were for the weeks ending 9/7/25 and 9/14/25 and did not include the current or following week.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

During the time of inspection, the menus were posted in a conspicuous and public place. The administrator, or designee, will sign off weekly that the menus were posted and subsequently file the old menus stored in the menu repository. The RCC will be trained on this document and the administrator will ensure compliance for future menu postings. All kitchen staff will be trained on this regulation at the next in-service meeting on 10/29 by the administrator and the training records will be kept in accordance with 2600.65(i).

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented [redacted] - 12/03/2025)

183d - Prescription Current

17. 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

At approximately 2:44 p.m., resident #3's Amlodipine 5mg tablet was found on the home's medication cart, however, the Amlodipine 5mg tablet was discontinued on 9/16/25 and replaced with Amlodipine 10mg tablet.

183d - Prescription Current (continued)

REPEAT VIOLATION 8/27/24 et. al.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

Resident #3s prescription has been updated per the physician's orders- the DC'ed script was removed from the cart and the updated order was added. This was completed by the RCC on 10/2/25. The Medication Supervisor or Administrator will conduct monthly medication audits to verify that all medications in the home are current and prescribed for residents presently living in the facility. Starting the week of 10/13. Medication trained staff will receive training on proper medication storage, disposal, and documentation procedures at the next inservice by 10/31 by the administrator or designee. A log will be maintained for medication disposal, including the date, medication name, quantity, and staff signatures verifying proper removal.

Licensee's Proposed Overall Completion Date: *10/31/2025*

Implemented [redacted] - 12/03/2025)

[redacted]

185a - Implement Storage Procedures

19. 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 #3's Freestyle Freedom Lite glucometer indicated a reading of 172 bs/dL on 9/23/25 at 10:43 a.m., however the resident's medication administration record for September 2025 indicated a reading of 142 bs/dL on 9/23/25 at approximately 1:00 p.m.

Resident #3's Ondansetron 8mg, take 1 tablet under the tongue every 6 hours as needed was not on the cart or in the home to administer if requested by the resident.

Resident #4 was prescribed Lorazepam 2mg/2mL oral concentrate, give 0.25mLs (0.5mg) under the tongue every 6 hours as needed. However, resident #4's Lorazepam was not available on the medication cart or in the home to administer if requested by the resident.

Plan of Correction ***Accept[redacted] - 10/20/2025)***

Resident #3 glucometer has been recalibrated for accuracy. Resident #4 and #4 PRNs have been reordered from the pharmacy. Starting 10/13, The administer or designee will conduct weekly audits of medication storage and access areas to ensure ongoing compliance with security procedures. All medication technicians will be trained on the proper use of the pharmacy label and sign off on training by 10/31 and kept in accordance with 2600.65.(i). Medication trained staff will receive refresher training every six months on medication security, storage, and distribution procedures. Policies and Procedures regarding the safe storage and handling of medications and medical equipment will be reviewed annually and updated as necessary to meet DHS regulation.

Licensee's Proposed Overall Completion Date: *10/31/2025* Not Implemented [redacted] - 12/03/2025)

187a - Medication Record

20. Requirements

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

Description of Violation

Resident #4 was prescribed Metoprolol 100mg tablet, take by mouth ½ tablet daily, hold for systolic blood pressure less than 110 and heart rate less than 55. However, resident #4's September 2025 medication administration record did not include an area to document the resident's systolic blood pressure or heart rate.

Plan of Correction ***Directed[redacted] - 10/20/2025)***

An order for Resident #4 parameters to be recorded has been added to the residents eMAR as an order parameters for this medication. All medication technicians will be trained by the RCC on the proper use of a blood pressure cuff to ensure correct readings and subsequent recording in the eMAR by 10/31 and training records kept in accordance with 2600.65.(i).

187a - Medication Record (continued)

Proposed Overall Completion Date: 10/31/2025

DIRECTED
Within three days of receipt of the plan of correction: The administrator or designee qualified to administer medications shall conduct an initial and monthly audit of all resident MARs to ensure accuracy and completeness. Documentation of audits shall be kept/ [redacted] 10/20/25

Directed Completion Date: *10/31/2025* Not Implemented [redacted] - 12/03/2025

187d - Follow Prescriber's Orders

21. Requirements

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

Description of Violation

Resident #3 was prescribed Amlodipine 10mg tablet, take one tablet by mouth once daily. However, on dates ranging from 9/17/25 through 9/25/25, resident #3 was administered a 5mg tablet of Amlodipine once daily.

Resident #4 was prescribed Metoprolol 100mg tablet, take by mouth one-half tablet daily, hold for systolic blood pressure less than 110 and heart rate less than 55. However, resident #3's Metoprolol was distributed as 50mg tablets split in half, and staff interviews indicated the resident was administered 25mg of Metoprolol for all of September 2025.

Resident #4 was prescribed Quetiapine 25mg tablet, take by mouth 1 tablet at bedtime. However, resident #3's Quetiapine was not available to administer to the resident from 9/1/25 through 9/25/25.

REPEAT VIOLATION 3/10/25, 8/27/24 et. al.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

On 10/1/2025, the Medication Supervisor and Administrator corrected all medication errors for Residents #3 and #4, ensuring Amlodipine, Metoprolol, and Quetiapine were administered per prescriber orders. Both residents, their designated persons, and their prescribers were notified the same day, and the prescribers' directions were followed. Incident reports will be filed by 10/21/2025, and documentation added to each resident's permanent record. All medication-trained and direct care staff will be retrained on medication administration, prescriber order compliance, and error reporting by 10/31/2025, with documentation maintained per §2600.65(i). Weekly MAR audits comparing orders to prescriptions will be conducted by the Medication Supervisor or Administrator, with findings documented. Beginning 10/31/2025, a two-staff verification system for all new or changed medication orders will be implemented to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/31/2025* Not Implemented [redacted] - 12/03/2025)

224a - Preadmission Screen Form

22. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

224a - Preadmission Screen Form *(continued)*

Description of Violation

Resident #1's preadmission screening, dated [redacted]/24, does not indicate whether or not the resident can safely use and avoid poisonous materials and does not include a determination that the needs of the resident can be met by the services provided by the home.

Resident #3's preadmission screening, dated [redacted]/25, does not indicate whether the resident can safely use and avoid poisonous materials.

Plan of Correction ***Accept [redacted] - 10/20/2025)***

Resident #1 and #3 preadmission screenings have been corrected for completion with an addendum. The administrator or designee will audit all pre-admission screenings by 10/31 to ensure completion. The Resident Care Coordinator (RCC) will be trained on requirement for completion of the preadmission screening by the administrator on or before 10/31 to ensure compliance for future submissions. Training will be given by the administrator and recorded per 2600.65(i). Audits will be completed monthly by the administrator for all new residents to ensure compliance with 2600.224 and be signed off on in TabulaPro for record keeping.

Licensee's Proposed Overall Completion Date: *10/31/2025* Not Implemented [redacted] - 12/03/2025)

227a - Support Plan 30 Days

23. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #2's support plan, dated [redacted]/25, does not indicate that the resident received services from Advantage Hospice, their contact info as a formal support, which service needs they provide, and the frequency that Advantage Hospice provides the service needs.

Plan of Correction ***Accept ([redacted] - 10/20/2025)***

Resident #2 support plan has been updated to reflect the correct hospice group, contract information, services provided and frequency of service. The administrator or designee will audit all care plans by 10/31 to ensure completion and accuracy. The Resident Care Coordinator (RCC) will be trained on requirement for completion and accuracy of the care plan by the administrator on or before 10/31 to ensure compliance for future submissions. Training will be given by the administrator and recorded per 2600.65(i). Care plans will be audited monthly for new residents and for 10% of the current residents and signed off on/updated in TabulaPro for record keeping.

Licensee's Proposed Overall Completion Date: *10/31/2025* Not Implemented [redacted] - 12/03/2025)

227d - Support Plan Medical/Dental

24. 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.

227d - Support Plan Medical/Dental *(continued)*

Description of Violation

Resident #4's most recent support plan, dated [redacted]/25, included an addendum, dated [redacted]/25, that indicated the resident had been admitted to hospice; however, it was not indicated that Medi Home Hospice is the provider or their contact information as a formal support. Additionally, the services provided by Medi Home Hospice, to include management of the resident's medications, were not included in the support plan addendum.

REPEAT VIOLATION 3/10/25

Plan of Correction ***Accept [redacted] - 10/20/2025)***

Resident #4 support plan has been updated to reflect the correct hospice group, contract information, services provided and frequency of service. The administrator or designee will audit all care plans by 10/31 to ensure completion and accuracy. The Resident Care Coordinator (RCC) will be trained on requirement for completion and accuracy of the care plan by the administrator on or before 10/31 to ensure compliance for future submissions. Training will be given by the administrator and recorded per 2600.65(i). Care plans will be audited monthly for new residents and for 10% of the current residents and signed off on/updated in TabulaPro for record keeping.

Licensee's Proposed Overall Completion Date: *10/31/2025* Not Implemented [redacted] - 12/03/2025)

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

Facility Information

Name: *SYCAMORE ESTATE PERSONAL CARE RESIDENCE* **License #:** *45450* **License Expiration:** *12/17/2025*

Address: *717 DUQUESNE BLVD, DUQUESNE, PA 15110*

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

Administrator

Name: [redacted]

Legal Entity

Name: *SYCAMORE ESTATES, LLC*

Address: *717 DUQUESNE BLVD, DUQUESNE, PA, 15110*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *05/14/1999* **Issued By:** *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *33* **Waking Staff:** *25*

Inspection Information

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

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

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *49* **Residents Served:** *26*

Secured Dementia Care Unit

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

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *4* **Are 60 Years of Age or Older:** *26*

Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability:** *2*

Have Mobility Need: *7* **Have Physical Disability:** *0*

Inspections / Reviews

11/06/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/19/2025*

Inspections / Reviews *(continued)*

11/20/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/02/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/25/2025*

11/21/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/02/2025*

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

12/03/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/02/2025*

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

132d - Evacuation

1. 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

On 10/30/25 at 4:08 p.m. the home conducted a fire drill with an evacuation time of 3 minutes and 45 seconds. However, there was no maximum safe evacuation time documented in writing by a fire safety expert and the default time was 2 minutes and 30 seconds.

Plan of Correction ***Accept [redacted] - 11/21/2025)***

The fire safe letter with the updated and confirmed maximum evacuation time was obtained on 11.6.25 stating the max time remains at 5min, see attached. All recorded fire drills have been consistent with this timing.

The administrator or designee shall audit the fire drill record monthly to ensure an unannounced fire drill shall be held at least once a month to ensure residents are evacuated from 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. The administrator or designee will confirm the fire safe letter is still valid prior to the fire drill being held. If the fire safe letter is to be invalid at the time of the fire drill, the administrator or designee shall complete the following steps to reduce the safe evacuation to a time less than 2 minutes and 30 seconds, or a fire safe evacuation time specified by a fire safety expert.

- *Request a decrease in licensed capacity and discharge residents.*
- *Provide resident and staff education on evacuation policies and procedures. Documentation will be kept.*
- *Conduct additional fire drills.*
- *Relocate residents who require special assistance with evacuation closer to exits or fire-safe areas.*
- *Add additional staff (at all times) to meet the 2 minute and 30 second evacuation time or the safe evacuation time specified by the fire safety expert within the past year.*

Licensee's Proposed Overall Completion Date: *11/21/2025* Not Implemented [redacted] - 12/03/2025)

141a 1-10 Medical Evaluation Information

2. Requirements

2600.

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

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's initial medical evaluation, dated [redacted]/25, did not include the resident's height, weight, medication self-administration, body positioning/movement, or the medical professional's signature, those areas were left blank.

Plan of Correction ***Accept [redacted] - 11/21/2025)***

Resident #1's DME was completed on [redacted]25, including the specific areas called out in the violation. The incorrect DME (incomplete) was mistakenly shared with the DHS agent. Training was completed for the Resident Care Coordinator on the proper completion of DMEs on 10/29 and records will be kept in accordance with 2600.65(i). An audit of all resident DMEs was started on 11/7/25 and will be completed on 11/30/25. The administrator will audit 10% of resident DMEs over the next three months to ensure completion and accuracy.

Licensee's Proposed Overall Completion Date: *11/30/2025* Not Implemented [redacted] - 12/03/2025)

184a - Resident's Meds Labeled

3. 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

The pharmacy label for resident #3's Loperamide 2mg capsule indicated, "Take one capsule by mouth four times a day as needed." However, resident #3 was prescribed Loperamide 2mg capsule, take by mouth two capsules after first loose stool and one capsule after each additional loose stool as needed, not to exceed four capsules in twenty-four hours.

Plan of Correction ***Accept [redacted] - 11/21/2025)***

Resident #3's Loperamide 2mg capsule has been labeled with a "change of direction see chart" sticker to indicate the change from the MAR to the pharmacy label, this was completed on 11/6/25. All Medication technicians were trained on 10/31 on 2600.184 by the Resident Care Coordinator and documentation will be kept in accordance with 2600.65(i). On 11/13/25, the Resident Care Coordinator completed an initial medication cart audit verifying there were no discontinued and/or expired medications in the medication cart. Resident Care Coordinator or Designee will complete a medication cart audit weekly x 3 weeks then monthly x 2 months. Resident Care Coordinator or Designee will have this completed by 1/31/26.

Licensee's Proposed Overall Completion Date: *11/21/2025* Not Implemented [redacted] - 12/03/2025)

185a - Implement Storage Procedures

4. 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 #3's glucometer indicated a reading of 224 bs/dL on 11/4/25 at 11:25 a.m., however, the resident's medication administration record for November 2025 documented a reading of 212 bs/dL on 11/4/25 at 1:00 p.m.

Resident #4's glucometer indicated a reading of 201 bs/dL on 11/5/25 at 1:39 p.m., however, the resident's medication administration record for November 2025 did not document a reading on 11/5/25 at 12:00 p.m.

Resident #4's glucometer indicated a reading of 247 bs/dL on 11/3/25 at 1:38 p.m., however, the resident's medication administration record for November 2025 did not document a reading on 11/5/25 at 12:00 p.m.

Resident #4's glucometer indicated a reading of 101 bs/dL on 11/1/25 at 10:18 a.m., however, the resident's medication administration record for November 2025 documented a reading of 142 bs/dL on 11/1/25 at 9:00 a.m.

Resident #4 was prescribed Hyoscyamine SL 0.125mg tablet, dissolve one tablet under the tongue every four hours as needed. However, the Hyoscyamine tablet was not on the cart or in the home to administer if requested by the resident.

Resident #4 was prescribed Lorazepam 2mg/mL oral concentrate, give 0.25mLs (0.5mg) under tongue every six hours as needed. However, the Lorazepam 2mg/mL oral concentrate was not on the cart or in the home to administer if requested by the resident.

Resident #4 was prescribed Ibuprofen 800mg tablet, take one tablet by mouth 3 times a day as needed. However, the Ibuprofen 800mg tablet was not on the cart or in the home to administer if requested by the resident.

Plan of Correction ***Directed [redacted] - 11/21/2025)***

Resident #4 who prescribed Hyoscyamine SL 0.125mg tablet, dissolve one tablet under the tongue every four hours as needed- was on the cart with 12 remaining tablets as of the 11/13/25 med cart audit.

Resident #4 who was prescribed Lorazepam 2mg/mL oral concentrate, give 0.25mLs (0.5mg) under tongue every six hours as needed- was DC'ed on 11/6/25.

Resident #4 who was prescribed Ibuprofen 800mg tablet, take one tablet by mouth 3 times a day as needed- was on the cart with 28 remaining tablets as of the 11/13/25 med cart audit.

All sugar readings are recorded in a notebook, including these specific residents for dates and times. All Medication technicians were trained on 10/31 on 2600.185 by the Resident Care Coordinator and documentation will be kept in accordance with 2600.65(i). On 11/13/25, the Resident Care Coordinator completed an initial medication cart audit which included the verification of glucose reading accuracy. Resident Care Coordinator or Designee will complete a medication cart audit weekly x 3 weeks then monthly x 2 months to ensure accuracy of glucose readings. Resident Care Coordinator or Designee will have this completed by 1/31/26.

185a - Implement Storage Procedures (continued)

Proposed Overall Completion Date: 11/21/2025

DIRECTED
Within 5 days of receipt of the plan of correction: The administrator shall educate all medication staff persons regarding the regulation and the home's policy and procedures. Documentation of education will be kept in accordance with Regulation 2600.65(i).

Directed Completion Date: *11/26/2025* Not Implemented [redacted] - 12/03/2025)

186a - Authorized Prescriber

5. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

Resident #1 was admitted on [redacted]/25 and the personal care home received a blister pack of Dulcolax 5mg tablets with a pharmacy label that indicated the tablets were dispensed September 2024 and to "give one tablet by mouth every day as needed." However, on 11/6/25, it was determined that the home did not have a current prescription in writing by an authorized prescriber for the Dulcolax 5mg tablet.

Plan of Correction ***Directed [redacted] - 11/21/2025)***

On November 6th, an authorized prescriber renewed the script for Dulcolax (generic) 5mg tablet by mouth every day as needed. All Medication technicians were trained on 10/31 on 2600.187 by the Resident Care Coordinator and documentation will be kept in accordance with 2600.65(i). Resident Care Coordinator completed an initial medication cart audit on 11/13/15 verifying there were no discontinued and/or expired medications in the medication cart and all medication was present per orders. Resident Care Coordinator or Designee will complete a medication cart audit weekly x 3 weeks then monthly x 2 months. Resident Care Coordinator or Designee will have this completed by 1/31/26

Proposed Overall Completion Date: 11/21/2025

DIRECTED
Within 5 days of receipt of the plan of correction: The administrator shall educate all medication staff persons regarding the regulation and the home's policy and procedures. Documentation of education will be kept in accordance with Regulation 2600.65(i).

Directed Completion Date: *11/26/2025*

Implemented [redacted] - 12/03/2025)

187a - Medication Record

6. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
11. Special precautions, if applicable.

187a - Medication Record *(continued)*

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #1 was prescribed Atorvastatin 20mg tablet, take one tablet by mouth daily, however, the resident's November medication administration record did not indicate the purpose of the medication.

Resident #4 was prescribed Metoprolol 100mg tablet, take by mouth ½ tablet daily, hold for systolic blood pressure less than 110 and heart rate less than 55. However, resident #4's October 2025 medication administration record and November 2025 medication administration record did not include an area to document the resident's systolic blood pressure or heart rate.

Plan of Correction ***Directed [redacted] - 11/21/2025)***

Resident #1 diagnosis for the prescribed drug was added to the MAR.
Resident #4 BP was recorded in a daily notebook maintained by medtechs. The MAR has been addressed so the BP reading is now required at each administration on the eMAR.
All Medication technicians were trained on 10/31 on 2600.187 by the Resident Care Coordinator and documentation will be kept in accordance with 2600.65(i).
Resident Care Coordinator or Designee will complete a medication cart audit weekly x 3 weeks then monthly x 2 months to confirm the recorded values are correct on the MAR and all diagnosis are evident on the MAR. Resident Care Coordinator or Designee will have this completed by 1/31/26

Proposed Overall Completion Date: 11/21/2025

DIRECTED
Within 5 days of receipt of the plan of correction: The administrator shall educate all medication staff persons regarding the regulation and the home's policy and procedures. Documentation of education will be kept in accordance with Regulation 2600.65(i).

Directed Completion Date: *11/26/2025* Not Implemented [redacted] - 12/03/2025)

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident #4 was prescribed Metoprolol 100mg tablet, take by mouth one-half tablet daily, hold for systolic blood pressure less than 110 and heart rate less than 55. However, resident #4's Metoprolol was distributed as 50mg tablets split in half, and staff interviews indicated the resident was administered 25mg of Metoprolol for all of October 2025 and from 11/1/25 through 11/6/25.

Resident #5 was prescribed Cipro 500mg tablet, give one tablet by mouth once daily on 11/1/25. However, this medication was not administered to resident #5 on dates to include 11/1/25 through 11/6/25 because the medication was not available in the home.

Resident #5 was prescribed Furosemide 20mg tablet, give one tablet by mouth in the morning. The resident's Furosemide 20mg tablet order was changed on 10/29/25 to give one tablet by mouth twice daily. However, this medication was not administered to resident #5 on dates to include 11/1/25 through 11/5/25 and on the morning of

187d - Follow Prescriber's Orders (continued)

11/6/25 because the medication was not available in the home.

REPEAT VIOLATION 3/10/25, 8/27/24 et. al.

Plan of Correction ***Accept [redacted] - 11/21/2025)***

Resident #4 Metoprolol dosage and administration was corrected on the MAR to indicate "one tablet by mouth daily, 50mg".
Resident #5 Cipro 500mg was ordered by hospice for 7 days, from 10/22-10/29. On 11/6 during a nurse visit, another order of 7 days 2x daily was ordered and then DC'ed on 11/10 for the completion of the therapy.
Resident #5 on 11/6 a reorder was issued for the Furosemide and on 11/7 resident #5 resumed being administered the medication per orders.

The home's policy for receiving medication was reviewed by the administrator and RCC on 10/30. All Medication technicians were trained on 10/31 and records will be kept in accordance with 2600.65(i). Resident Care Coordinator or Designee will complete a medication cart audit weekly x 3 weeks then monthly x 2 months to ensure no expired or DC'ed meds are present but also that all required medication is present in the home. Resident Care Coordinator or Designee will have this completed by 1/31/26.

Licensee's Proposed Overall Completion Date: *11/21/2025* Not Implemented[redacted] - 12/03/2025)

224a - Preadmission Screen Form

8. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1's preadmission screening form, dated [redacted]3/25, did not include the signature of the person completing the screening and did not indicate the level of supervision needed or ability to self-administer medications.

Resident #5's preadmission screening form, dated [redacted]/25, did not indicate the level of supervision needed.

Plan of Correction ***Accept [redacted] - 11/21/2025)***

Resident #1 preadmission screening form has been signed by the individual who completed the screening and the level of super vision needed or the ability to self-administer medications has been completed.
Resident #5 preadmission screening form level of supervision needed has been corrected.

The RCC has been trained on the completion of the preadmission screen form on 10/31 and records will be kept in accordance with 2600.65(i). The administrator has started an audit on all preadmission documents for recent (within last 6 months)active residents to ensure completion and accuracy on 11/19/25 and will be completed by 11/24/25. The administrator will conduct an audit on all incoming and submitted preadmission screenings to ensure completion and accuracy.

224a - Preadmission Screen Form *(continued)*

Licensee's Proposed Overall Completion Date: *11/24/2025* Not Implemented [redacted] - 12/03/2025)

225a - Assessment 15 Days

9. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #1's initial assessment, dated [redacted]/25, did not include a supervision assessment or medication self-administration assessment, those areas were left incomplete.

Plan of Correction ***Accept [redacted] 11/21/2025)***

Resident #1 initial assessment has been corrected to include a supervision assessment or medication self-administration assessment. The RCC has been trained on the requirement for documentation timelines on 10/31 and records will be kept in accordance with 2600.65(i). The administrator has started an audit on all initial assessment documents for recent (within last 6 months)active residents to ensure completion and accuracy on 11/19/25 and will be completed by 11/24/25. The administrator will conduct an audit on all submitted initial assessments to ensure completion and accuracy.

Licensee's Proposed Overall Completion Date: *11/24/2025* Not Implemented [redacted] - 12/03/2025)

227a - Support Plan 30 Days

10. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1's initial support plan, dated [redacted]/25, indicated services from Amedisys Hospice with a nurse visiting once per week and aide visiting five times per week, however, the support plan did not indicate the care and services to be provided to resident #1.

Plan of Correction ***Accept [redacted] - 11/21/2025)***

Resident #1 initial support plan has been corrected to indicate that Amedisys Hospice will provide "an aide 5 days a week and a nurse once a week seeing her. Hospice will provide all of her supplies including incontinence supplies, general personal hygiene supplies and medications as well as personal care and skin care. "
The RCC has been trained on the completion of Care plans for completion and accuracy on 10/31 and records will be kept in accordance with 2600.65(i). The administrator has started an audit on all support plans for recent (within last 6 months)active residents to ensure completion and accuracy on 11/19/25 and will be completed by 11/24/25 and will audit 10% of care plans for the next three months o ensure completion and accuracy to 2600.227 is being met.

Licensee's Proposed Overall Completion Date: *11/24/2025* Not Implemented [redacted] - 12/03/2025)