pennsylvania
DEPARTMENT OF HUMAN SERVICES

Certificate of Compliance

This certificate is hereby granted to **WATERMARK OPERATOR, LLC**
LEGAL ENTITY

To operate **ROSE TREE PLACE**
NAME OF FACILITY OR AGENCY

Located at **500 SANDY BANK ROAD, MEDIA, PA 19063**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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PROVISIONAL

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 **149**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 26**

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 **May 22, 2026** until **November 22, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **132811**

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: MAY 22, 2026

Authorized Signatory
Watermark Operator, LLC

RE: Rose Tree Place
License #: 132811

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection November 13, 14, and 18, 2025 and January 22, 2026 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificates of compliance numbers 132810 dated June 21, 2025 to June 21, 2026 and from June 21, 2026 to June 21, 2027 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from May 22, 2026 to November 22, 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)
82c	II	110	$5	$550	5 calendar days from mailing date of this letter
191	III	110	$3	$330	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 FIRST 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 FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
[redacted]

Mr. David Barnes

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:

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *ROSE TREE PLACE* **License #**: *13281* **License Expiration**: *06/21/2026*

Address: *500 SANDY BANK ROAD, MEDIA, PA 19063*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *WATERMARK OPERATOR, LLC*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *11/12/1999* **Issued By**: *CWOPA L&I*
Type: *Other* **Date**: *01/13/2010* **Issued By**: *Upper Providence Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *178* **Waking Staff**: *134*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *01/05/2026*

Inspection Dates and Department Representative

11/13/2025 *On Site*: [redacted]
11/14/2025 *On Site*: [redacted]
11/18/2025 *On Site*: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *149* **Residents Served**: *102*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SCDU* **Capacity**: *26* **Residents Served**: *23*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *100*
Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *76* **Have Physical Disability**: *0*

Inspections / Reviews

11/13/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/15/2026*

03/10/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/06/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/15/2026*

04/13/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/12/2026*

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

04/15/2026 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *04/13/2026*

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

18 - Compliance With Laws

1. Requirements

2600.

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

Description of Violation

According to Delaware County Health Department the home has been cited for the following violations:

- ***Violation 3 Refuse, Liquid/Solid Waste and Laundry***
  Correct By = [redacted]
  404.2. Bloodborne pathogen spill kit is not stocked.
- ***Violation 4 Prevention of Gastrointestinal Disease Outbreaks***
  Correct By = [redacted]
  404.3 Facility was unable to provide a Gastrointestinal Outbreak Policy that is reviewed with employees.
  404.3.5. Facility does not have a clear and posted policy on Employee Health Reporting.
  406.23.2. A test kit or other device must be available that accurately measures the concentration in mg/L or parts per
  millions of sanitizing solution(s) mixed on-site.
- ***Violation 8 Food Facility***
  Correct By = [redacted]
  404.2.7.1. The institution has a food facility but does not have a valid Food Facility License issued from the Department.

Personal care and assisted living homes must post the required influenza information in a public place in the home year-round as required by the Influenza Awareness Act (HB 1785).

On [redacted], There was no current Flu Poster posted in the Memory care area.

Plan of Correction ***Accept [redacted] - 03/10/2026)***

Correction: Bloodborne pathogen spill kits stocked. GI Outbreak Policy and Employee Health Reporting Policy finalized and reviewed. Sanitizer test kits obtained. Food Facility License application submitted. Current Influenza Awareness Act poster posted in Memory Care.

Prevention: Annual regulatory compliance checklist implemented.

Monitoring: Quarterly audits by Administrator or designee.

Responsible: Administrator

Forms have been submitted, currently waiting on licenses

18 - Compliance With Laws *(continued)*

Not Implemented - 04/13/2026)

41c Rights Poster

2. Requirements

2600.
41.c. The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the home.

Description of Violation

The Department's resident's rights poster is not posted in a conspicuous and public place in the home's memory care area.

Plan of Correction ***Accept - 03/10/2026)***

Corrected onsite

Prevention: Poster placement added to environmental checklist.

Monitoring: Monthly environmental rounds.

Responsible: Administrator

Completion Date: 11/10/2025

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented 04/13/2026)

42b Abuse

3. 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

On at around 6:00 pm, Resident began to choke on their meal. The meal consisted of garlic bread and beef ravioli. Resident was prescribed a special diet of chopped meats and mechanical soft. On during dinner Resident also experienced a choking incident involving broccoli. Resident s diet was changed at that time to mechanical soft and chopped meats with a referral to speech therapy.

On , Resident experienced concern with taking pills and had difficulty swallowing. There was no referral to have Resident evaluated to change diet to one they can tolerate without choking. On Resident date of death, Resident was pronounced deceased at the hospital.

On at around 8:00 am, Resident had a fall in their room hitting their head on the end table by their bed. Staff under the room heard the thump but did not go to see what the thump was. Resident had requested that they not have sleeping hour checks during the hours of 11 pm through 7 am. At around 8:56 am according to Staff Person B they went to check why Resident did not come down to breakfast and found them on the floor with a head injury

42b Abuse (continued)

and a skin tear to their arm. Staff Person B did not perform CPR because according to their assignment sheet Resident █ had a Do Not Resuscitate order. Staff Person B went to get the Nurse on Duty. Emergency services were called and Resident █ was pronounced deceased at 9:00 am.

Plan of Correction ***Accept █ - 03/13/2026)***

Incident Investigation

The Administrator and Director of Nursing completed a full internal investigation of both incidents, including review of medical records, dining documentation, incident reports, and staff interviews.

Resident █ Swallowing/Diet Safety

Dining and care staff assignments were reviewed to confirm awareness of therapeutic diets and diet texture requirements.

The dining service team and caregiving staff were immediately re educated on:

Mechanical soft diet requirements

Choking prevention procedures

Monitoring residents with swallowing concerns

Escalation procedures when swallowing difficulty is observed

Speech therapy referral procedures were reviewed with nursing staff to ensure timely evaluations when swallowing difficulties are identified.

Resident █ Fall Response and Emergency Protocol

Staff involved in the incident were immediately counseled and re educated regarding:

Immediate response to unusual sounds or potential falls

Required response procedures regardless of resident preferences for overnight checks

Emergency response procedures

CPR and DNR protocol clarification

Staff were re educated that CPR must be initiated unless a valid DNR order is verified and emergency services have been contacted.

Emergency Response Reinforcement

42b - Abuse (continued)

A review of emergency response protocols was completed with all care staff to ensure appropriate response to choking, falls, and medical emergencies.

Staff Training Completed

The following staff members received mandatory retraining on resident safety, choking response, diet compliance, fall response procedures, and CPR/DNR clarification:

Care Staff assigned to dining and resident care during the incidents

All Resident Assistants

Medication Technicians

Licensed Nursing Staff

Dining Services Staff involved in meal service

Training was conducted by the Director of Nursing and Administrator on the following dates:

November 5, 2025 – Emergency Response and Choking Protocol

November 7, 2025 – Therapeutic Diet Compliance and Swallowing Precautions

November 12, 2025 – Fall Response Procedures and Emergency Escalation

November 14, 2025 – CPR/DNR Clarification and Emergency Protocol

Attendance records and training documentation are maintained in the community training files.

Measures Implemented to Prevent Recurrence

To prevent recurrence and ensure continued compliance, the following procedures have been implemented:

Diet Compliance Process

Therapeutic diet lists are now verified daily between nursing and dining staff.

Dining staff confirm resident diet texture requirements prior to meal service.

Swallowing Concern Escalation

Any resident exhibiting difficulty swallowing will be reported immediately to the nurse on duty.

42b - Abuse (continued)

Nursing staff will initiate a physician notification and speech therapy referral when appropriate.

Fall and Emergency Response Expectations

Staff must immediately investigate any loud noise, fall, or distress sound heard from resident rooms.

Staff are required to respond immediately regardless of sleep check preferences.

CPR and DNR Clarification

DNR status must be verified through the resident chart prior to withholding CPR.

Emergency services must be contacted immediately in any unresponsive resident situation.

Monitoring and Quality Assurance

To ensure ongoing compliance, the following monitoring processes have been implemented:

1. Diet Compliance Audits

Start Date: November 15, 2025

Frequency: Weekly for 4 weeks, then monthly thereafter

Responsible Party: Director of Nursing / Dining Director

Method:

Random review of resident meal trays

Verification of diet texture compliance

2. Incident Report Review

Start Date: November 15, 2025

Frequency: Weekly review of all incidents for 90 days, then monthly

Responsible Party: Administrator and Director of Nursing

Method:

Review of choking incidents, falls, and emergency responses

3. Resident Safety Rounds

42b - Abuse (continued)

Start Date: November 18, 2025

Frequency: Weekly safety rounds

Responsible Party: Director of Nursing / Resident Care Director

Method:

Observation of staff response readiness

Review of resident care practices

4. Staff Competency Validation

Start Date: December 2025

Frequency: Annual competency and new hire orientation training

Responsible Party: Director of Nursing

Method:

Demonstration of choking response procedures

Review of fall response protocols

CPR/DNR policy review

Findings from audits and monitoring activities will be reviewed during Quality Assurance meetings and corrective actions will be implemented as needed.

Responsible Parties

Administrator
Director of Nursing
Dining Director

Completion Date

February 15, 2026

If you'd like, I can also tighten this to fit SansWrite character limits (inspectors often require shorter POCs) or format it into a clean Word document like the inspection submission packets you typically send for Rose Tree Place.

42b - Abuse *(continued)*

Licensee's Proposed Overall Completion Date: *03/12/2026*

Not Implemented ███ - 04/13/2026)

44g - Telephone Number

4. Requirements

2600.
44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone numbers of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP) the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline is not posted in a conspicuous and public place in the home's memory care area.

Plan of Correction ***Accept ███ - 03/10/2026)***

Corrected onsite

Correction: Required telephone numbers posted in large print in Memory Care.

Prevention: Posting verification added to audit checklist.

Monitoring: Monthly audits.

Responsible: Administrator

Completion Date: 11/10/2025

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented ███ - 04/13/2026)

51 - Criminal Background Check

5. Requirements

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

Description of Violation

On ███ Staff Person C, hired ███, did not have a criminal background check in their record.

Plan of Correction ***Accept ███ - 03/10/2026)***

Corrected onsite

51 Criminal Background Check (continued)

Correction: Criminal background clearance for Staff Person C obtained and filed.

Prevention: Clearance verification required prior to first shift.

Monitoring: Monthly personnel file audits.

Responsible: Administrator / HR

Completion Date: 11/10/2025

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented 04/13/2026)

63a - First Aid/CPR Training

6. Requirements

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

Description of Violation

On , from 11 pm until 7:00 am, 102 residents were present in the home. During this time only 2 staff persons were present in the home who were certified in first aid, obstructed airway techniques and CPR.

On , from 11 pm until 7:00 am, 102 residents were present in the home. During this time only 1 staff person was present in the home who were certified in first aid, obstructed airway techniques and CPR.

Plan of Correction ***Accept (- 03/10/2026)***

Correction: Staffing schedules adjusted to ensure required CPR/First Aid certified staff coverage at all times.

Prevention: Certification tracking matrix implemented.

Monitoring: Weekly staffing review.

Responsible: Administrator

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented - 04/13/2026)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.

65f - Training Topics *(continued)*

Description of Violation

Direct care staff person D did not receive training in medication self-administration training during training year 2024.

Plan of Correction Repeat Violation: [redacted] et al. ***Accept ([redacted] - 03/10/2026)***

Correction: Staff Person D completed medication self-administration training.

Prevention: Annual training tracker implemented.

Monitoring: Quarterly training audits.

Responsible: Administrator

Completion Date: 02/01/2026

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented [redacted] - 04/13/2026)

65g - Annual Training Content

8. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation Repeat Violation: [redacted] et al.

Staff person D did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations during training year January 2024 to December 2024.

Staff person E did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations during training year January 2024 to December 2024.

Plan of Correction ***Accept [redacted] 03/10/2026)***

Correction: Staff Persons D and E completed emergency preparedness training.

Prevention: Annual emergency preparedness training schedule standardized.

Monitoring: Quarterly training review.

Responsible: Administrator

Completion Date: 02/01/2026

Licensee's Proposed Overall Completion Date: *02/15/2026*

65g - Annual Training Content *(continued)*

Not Implemented [redacted] 04/13/2026)

82c - Locking Poisonous Materials

9. Requirements

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

Description of Violation

Desitin Ointment, with a manufacture's label indicating "If swallowed get medical help or contact a Poison control right away", was unlocked, unattended, and accessible to residents in memory care. Not all the residents of the home, including all the residents in memory care, have been assessed capable of recognizing and using poisons safely.

Antiseptic Mouthwash, with a manufacture's label indicating "contact a Poison control right away", was unlocked, unattended, and accessible to residents in memory care. Not all the residents of the home, including all the residents in memory care, have been assessed capable of recognizing and using poisons safely.

Crest Toothpaste, with a manufacture's label indicating "contact a Poison control right away", was unlocked, unattended, and accessible to residents in memory care. Not all the residents of the home, including all the residents in memory care, have been assessed capable of recognizing and using poisons safely.

Repeat Violation: [redacted] et al.

Plan of Correction ***Accept [redacted] - 03/10/2026)***

Correction: All identified items were secured in locked storage

Prevention: Lock checks added to shift procedures.

Monitoring: Daily supervisory rounds

Responsible: Memory Care Director

Completion Date: Immediate

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented [redacted] - 04/13/2026)

85d - Trash Receptacles

10. 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

On [redacted] at 11:17 am there was a 1/2 full, uncovered, unattended trash can in the main kitchen.

85d - Trash Receptacles (continued)

On [redacted], there was a full uncovered trash can in the memory care kitchen

Plan of Correction ***Accept [redacted] 03/10/2026)***

Correction: Covered trash receptacles placed in kitchen and Memory Care.

Prevention: Sanitation policy reinforced with staff.

Monitoring: Daily kitchen inspections.

Responsible: Dining Director

Completion Date: 11/10/25

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented [redacted] - 04/13/2026)

86b - Bathroom

11. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom in room [redacted] does not have an operable window or ventilation fan. The exhaust fan is inoperable and there is no window in the bathroom.

Plan of Correction ***Accept [redacted] - 03/10/2026)***

Correction: Exhaust fan in Room [redacted] was repaired and verified operable.

Prevention: Preventive maintenance schedule updated through TELS.

Monitoring: Monthly maintenance inspections.

Responsible: Maintenance Director

Completion Date: 12/12/25

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented ([redacted] - 04/13/2026)

89b - Hot Water Temperature

12. Requirements

2600.

89b - Hot Water Temperature *(continued)*

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On [redacted] at 10:17 am, the hot water temperature at the bathroom in room [redacted] measured 126.3 degrees Fahrenheit.

On [redacted] at 10:29 am, the hot water temperature at the bathroom in room [redacted] measured 125.7 degrees Fahrenheit.

On [redacted] at 10:49 am, the hot water temperature at the bathroom in room [redacted] measured 124.7 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] 03/10/2026)***

Corrected onsite

Correction: Mixing valves adjusted to ensure water temperatures do not exceed 120°F.

Prevention: Routine temperature checks implemented.

Monitoring: Monthly temperature logs.

Responsible: Maintenance Director

Completion Date: 11/11/2025

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented [redacted] - 04/13/2026)

91 - Telephone Numbers

13. 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

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in [redacted]

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in [redacted]

91 - Telephone Numbers *(continued)*

Plan of Correction ***Accept - 03/10/2026)***

Corrected onsite

Correction: Emergency telephone numbers posted by telephones in Rooms and
Prevention: Room readiness checklist updated.

Monitoring: Monthly audits.

Responsible: Administrator

Completion Date: 11/11/25

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented 04/13/2026)

103g - Storing Food

14. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

The ice cream containers in the ice cream freezer were opened and unsealed.

Plan of Correction ***Accept (- 03/13/2026)***

Immediate Correction

The ice cream containers were immediately sealed and returned to proper storage in accordance with food storage requirements. The issue was identified during lunch service when ice cream was being served. At that time, the individual ice cream lids had been removed for service; however, the freezer lid remained closed. The containers were resealed immediately once the service was completed.

Staff Education

Dining services staff were re-educated on food storage requirements, specifically that all food items must remain covered or sealed when stored, including items located in freezer storage areas.

The Dining Director reviewed the regulation and proper storage procedures with all dining staff during a department meeting.

Preventive Measures

To prevent recurrence, the following procedures have been implemented:

Dining staff must ensure that all food items are sealed or covered immediately after serving is completed.

103g - Storing Food (continued)

All freezer and refrigerator food storage areas will be checked at the end of each meal service to ensure containers are properly sealed.

Staff are reminded to follow safe food storage practices as outlined in the community's food safety procedures.

Monitoring / Auditing for Compliance
Food Storage Spot Checks

Start Date: March 15, 2026

Frequency: Weekly for 30 days, then monthly thereafter

Responsible Party: Dining Director or designee

Method:

Visual inspection of refrigerators and freezers

Verification that all food items are stored in sealed or covered containers

Kitchen Sanitation and Storage Audit

Start Date: March 15, 2026

Frequency: Monthly

Responsible Party: Administrator / Dining Director

Method:

Review of kitchen food storage practices

Verification of compliance with food safety regulations

Quality Assurance Review

Frequency: Quarterly

Responsible Party: Administrator and Dining Director

Method:

Review of food safety practices and any findings from storage audits during Quality Assurance meetings.

Any deficiencies identified during audits will be corrected immediately and staff will be re-educated as necessary.

103g Storing Food (continued)

Licensee's Proposed Overall Completion Date: *03/12/2026*

Not Implemented █ - 04/13/2026)

103i - Outdated Food

15. Requirements

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

Description of Violation

There were unlabeled, undated 6 unidentifiable frozen meats in the walk in freezer.

Plan of Correction ***Accept █ - 03/10/2026)***

Corrected onsite

Correction: Expired/unlabeled food discarded. All food sealed and labeled.

Prevention: Weekly food safety audits implemented.

Monitoring: Dietary inspections.

Responsible: Dining Director

Completion Date: 11/11/25

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented █ - 04/13/2026)

131f - Fire Extinguisher Inspection

16. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the vehicle has not been inspected by a fire safety expert since October 2024.

The fire extinguisher located near room █ has not been inspected by a fire safety expert since October 2024.

Plan of Correction ***Accept (█ - 03/10/2026)***

Correction: All fire extinguishers inspected and properly tagged.

Prevention: Annual fire safety calendar implemented.

131f - Fire Extinguisher Inspection (continued)

Monitoring: Annual inspection verification.

Responsible: Maintenance Director

Completion Date: 11/11/25

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented [redacted] - 04/15/2026)

162c - Menus Posted

17. 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 menu for the week of [redacted] and [redacted] was not posted in a conspicuous and public place in the home's memory care area.

Plan of Correction ***Accept[redacted] 03/10/2026)***

Corrected onsite

Correction: Menus posted in Memory Care.

Prevention: Menu posting added to dietary checklist.

Monitoring: Weekly verification.

Responsible: Dining Director

Completion Date: 11/10/2025

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented [redacted]- 04/13/2026)

181f - Record of Medication

18. Requirements

2600.
181.f. The resident's record shal[redacted]clude a current list of prescription, CAM and OTC medications for each resident who is self-administering [redacted] medication.

181f Record of Medication *(continued)*

Description of Violation

On , resident record did not include a current list of medications. The list in the resident's record did not include and .

Plan of Correction *Repeat Violation: et al.* ***Accept - 03/10/2026)***

Correction: Medication records corrected, discontinued medications removed, missing PRNs reordered, pharmacy coordination corrected, and locked storage enforced.

Prevention: Medication procedures reinforced and revised.

Monitoring: Weekly MAR audits.

Responsible: Director of Nursing

Completion Date: 02/10/2026

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented - 04/13/2026)

183b - Meds and Syringes Locked

19. Requirements

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

Description of Violation

On at 9:56 am, Overstock Medication cart was unlocked, unattended, and accessible in Alcove.

Plan of Correction ***Accept 03/10/2026)***

Correction: Medication records corrected, discontinued medications removed, missing PRNs reordered, pharmacy coordination corrected, and locked storage enforced.

Prevention: Medication procedures reinforced and revised.

Monitoring: Weekly MAR audits.

Responsible: Director of Nursing

Completion Date: 02/10/2026

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented - 04/13/2026)

183d - Prescription Current

20. Requirements

183d Prescription Current *(continued)*

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

Description of Violation

On ████ tablet prescribed for Resident █, was in the home's Medication cart; however, the medication was not on the current medication orders.

On ████ prescribed for Resident █ was in the home's Medication cart; however, the medication was not on the current medication orders.

On ████ prescribed for Resident █, was in the home's Medication cart; however, the medication was discontinued on ████

On ████, ████ capsule prescribed for Resident █ was in the home's Medication cart; however, the medication was discontinued on ████

Plan of Correction ***Accept █ - 03/10/2026)***

Correction: Medication records corrected, discontinued medications removed, missing PRNs reordered, pharmacy coordination corrected, and locked storage enforced.

Prevention: Medication procedures reinforced and revised.

Monitoring: Weekly MAR audits.

Responsible: Director of Nursing

Completion Date: 02/10/2026

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented █ 04/13/2026)

183e Storing Medications

21. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On ████ ████ tablet belonging to Resident █, was punctured in spots ████, ████ on the medication blister pack. There was tape on each spot covering them.

On ████ tablet belonging to Resident █, had punctures in spots █ and █ There was tape covering them.

On ████ tablet belonging to Resident █, had punctures in spot █ There was tape covering over them.

183e - Storing Medications (continued)

Plan of Correction ***Accept ███ 03/10/2026)***

Correction: Medication records corrected, discontinued medications removed, missing PRNs reordered, pharmacy coordination corrected, and locked storage enforced.

Prevention: Medication procedures reinforced and revised.

Monitoring: Weekly MAR audits.

Responsible: Director of Nursing

Completion Date: 02/10/2026

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented ███ - 04/13/2026)

185a - Implement Storage Procedures

22. Requirements

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

Description of Violation

Resident ███ is prescribed ███ tablet as needed. On ███ this medication was not available in the home.

Resident ███ is prescribed ███ as needed. On ███ this medication was not available in the home.

Resident ███ is prescribed ███ as needed. On ███ this medication was not available in the home.

Plan of Correction ***Accept (███ - 03/10/2026)***

Correction: Medication records corrected, discontinued medications removed, missing PRNs reordered, pharmacy coordination corrected, and locked storage enforced.

Prevention: Medication procedures reinforced and revised.

Monitoring: Weekly MAR audits.

Responsible: Director of Nursing

185a - Implement Storage Procedures (continued)

Completion Date: 02/10/2026

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented███ - 04/13/2026)

186b - Medication Used by Resident

23. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On ████████, Medication ████████████, belonging to Resident █ was discovered in the medication cart and included with Resident█s medication. The medication had a Post It note stating "stink, don't take off I'm using it for Resident █ because their medication is out." Resident█ is prescribed ██████████████

Plan of Correction ***Accept███ - 03/10/2026)***

Correction: Medication records corrected, discontinued medications removed, missing PRNs reordered, pharmacy coordination corrected, and locked storage enforced.

Prevention: Medication procedures reinforced and revised.

Monitoring: Weekly MAR audits.

Responsible: Director of Nursing

Completion Date: 02/10/2026

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented███ - 04/13/2026)

187d - Follow Prescriber's Orders

25. Requirements

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

Description of Violation

Resident is prescribed tablet. However, this medication was not administered to resident on at 5:00 pm because the medication was not available in the home.

Resident is prescribed . However, this medication was not administered to resident on at 9:00 pm because the medication was not available in the home.

capsule is prescribed to Resident . As of the home has not received this medication. The medication administration record documents this medication as last being administered on and at 9:00 AM

Plan of Correction ***Accept - 03/10/2026)***

Correction: Medication timing corrected and medication reordered.

Prevention: Medication reorder process reinforced.

Monitoring: Weekly MAR audits for 60 days.

Responsible: DON/LPN Supervisors

Completion Date: 02/08/2026

Licensee's Proposed Overall Completion Date: *02/17/2026*

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

Not Implemented [redacted] - 04/13/2026)

225a - Assessment 15 Days

26. 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

An assessment was not completed for resident [redacted] who was admitted to the home on [redacted]

Plan of Correction ***Accept [redacted] - 03/10/2026)***

Correction: Screening completed.

Prevention: Admission checklist revised.

Monitoring: Administrator admission review.

Responsible: Memory Care Director/DON

Completion Date: 02/06/2026

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented ([redacted] - 04/13/2026)

227g -Support Plan Signatures

27. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident [redacted] participated in the development of [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

Resident [redacted] participated in the development of [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

Plan of Correction ***Accept [redacted] - 03/10/2026)***

Correction: Support plan signed.

Prevention: Signature verification audits added.

Monitoring: Quarterly chart reviews.

Responsible: Memory Care Director

227g -Support Plan Signatures (continued)

Completion Date: 02/06/2026

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented - 04/13/2026)

231c - Preadmission Screening

28. 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 written cognitive preadmission screening was not completed.

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 - 03/10/2026)***

Correction: Screening completed.

Prevention: SDCU admission checklist updated.

Monitoring: Administrator review.

Completion Date: 02/06/2026

Responsible: Memory Care Director

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented 04/13/2026)

231e - No Objection Statement

29. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident was admitted to the Secure Dementia Care Unit (SDCU) on The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept (- 03/10/2026)***

Correction: Documentation obtained.

231e - No Objection Statement (continued)

Prevention: Added to SDCU admission packet.

Monitoring: Quarterly audits.

Completion Date: 02/06/2026

Responsible: Sales Director/Administrator

Licensee's Proposed Overall Completion Date: *02/17/2026*

Implemented [redacted] - 04/15/2026)

234a - Admission Support Plan

30. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was not completed.

Plan of Correction ***Accept [redacted] - 03/10/2026)***

Correction: Medication records corrected, discontinued medications removed, missing PRNs reordered, pharmacy coordination corrected, and locked storage enforced.

Prevention: Medication procedures reinforced and revised.

Monitoring: Weekly MAR audits.

Responsible: Director of Nursing

Completion Date: 02/10/2026

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented [redacted] - 04/13/2026)

236 - Staff Training

31. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person D, who works in the Secure Dementia Care Unit (SDCU) had only 1

236 - Staff Training (continued)

hours of training in dementia care during the January 2024 to December 2024 training year.

Direct care staff person E, who works in the Secure Dementia Care Unit (SDCU) had only 5 hours of training in dementia care during the January 2024 to December 2024 training year.

Plan of Correction Repeat Violation: [redacted] et al. ***Accept [redacted] - 03/10/2026)***

Correction: All missing dementia training will be completed.

Prevention: Training checklists revised.

Monitoring: Training completions to be monitored quarterly audits.

Responsible: Administrator / Memory Care Director/HR Director

Completion Date: 02/15/2026

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented [redacted] 04/13/2026)

252 - Record Content

32. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident [redacted] record does not include copy of Death Certificate.

Resident [redacted]s record does not include copy of Death Certificate.

Plan of Correction ***Accept [redacted] 03/10/2026)***

Resident [redacted] expired at the Hospital, no certificate needed per regulation.

Correction: Death certificates will be obtained and filed.

Prevention: Discharge checklist updated.

Monitoring: Quarterly record audits.

Responsible: DON

Licensee's Proposed Overall Completion Date: *02/17/2026*

Not Implemented ([redacted] - 04/13/2026)

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

Facility Information

Name: *ROSE TREE PLACE* **License #**: *13281* **License Expiration**: *06/21/2026*

Address: *500 SANDY BANK ROAD, MEDIA, PA 19063*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *WATERMARK OPERATOR, LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *11/12/1999* **Issued By**: *COPA L & I*
Type: *Other* **Date**: *01/13/2010* **Issued By**: *Upper Providence Township*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *189* **Waking Staff**: *142*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *01/22/2026*

Inspection Dates and Department Representative

01/22/2026 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *149* **Residents Served**: *114*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Pathways* **Capacity**: *26* **Residents Served**: *21*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *114*
Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *75* **Have Physical Disability**: *0*

Inspections / Reviews

01/22/2026 - Partial

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *02/15/2026*

02/24/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *02/17/2026*
Reviewer: [redacted]
Follow Up Type: *POC Submission*
Follow Up Date: *03/01/2026*

04/13/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *02/26/2026*
Reviewer: [redacted]
Follow Up Type: *Bypass Document Submission*

04/15/2026 Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *04/13/2026*
Reviewer: [redacted]
Follow Up Type: *Enforcement*

23a Activities of Daily Living Assistance

1. 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 transferring to bed from their wheelchair, and 2 staff are required. On , at 9:57 PM, the resident did not receive this assistance as required, as only 1 staff person assisted the resident in transferring from their wheelchair to their bed.

Plan of Correction ***Accept - 02/24/2026)***

Correction: Staff were immediately re-educated on following resident assessments and required two-person transfers. Staffing assignments adjusted.

Prevention: Transfer needs reinforced during shift change reports.

Monitoring: Weekly audits and observations by nursing leadership.

Completion Date: 02/15/2026

Licensee's Proposed Overall Completion Date: *02/15/2026*

Not Implemented (- 04/13/2026)

42b Abuse

2. 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 family of Resident provided the home with a video documenting the following incident:

On , at approximately 9:55 PM, Staff Person A was assisting Resident who uses a wheelchair, with a transfer from the wheelchair to the bed.

Staff Person A started the transfer by grabbing Resident by the left arm and the back of pajamas, then proceeded to push the resident towards the bed and drop face down onto the mattress. Staff Person A then lifted and turned Resident into a seated position on the side of the bed and then placed Resident onto back in a rough manner by lifting Resident legs and forcefully pushing onto the bed, causing Resident to fall backward with a jolt.

Plan of Correction ***Accept 03/10/2026)***

Correction: Staff removed from care and terminated from community. Resident assessed and family notified.

42b - Abuse (continued)

Prevention: Facility-wide retraining on safe transfers and abuse prevention.

Monitoring: Monthly unannounced transfer observations for 90 days.

Responsible Party: DON and Executive Director

Completion Date: 01/23/2026

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented - 04/13/2026)

65f - Training Topics

3. Requirements

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in medication self-administration training during training year through .

Repeat violation et al.

Plan of Correction ***Accept 03/10/2026)***

Correction: Missing medication self-administration training completed.

Prevention: Training tracker through Relias is monitored weekly.
Provide annual training on:

Hazard communication

Proper storage and handling

Emergency spill procedures

Document training completion.

Assign department heads responsibility for compliance checks (Nursing, Maintenance, Dining, Housekeeping).

65f Training Topics (continued)

Monitoring: Quarterly training record reviews.

Responsible Party: HR Director

Completion Date: 02/07/2026

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented [redacted] - 04/13/2026)

82c - Locking Poisonous Materials

4. Requirements

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

Description of Violation

Sensodyne, with a manufacturer's label indicating "If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in room [redacted] Not all the residents of the home, including Resident [redacted], have been assessed capable of recognizing and using poisons safely.

Repeat violation [redacted] et al.

Plan of Correction ***Accept [redacted] - 03/10/2026)***

Correction: Item immediately secured.

Prevention: Environmental safety checks reinforced.

Monitoring: Monthly safety rounds to ensure poisonous materials are secured.

Responsible Party: Memory Care Director and Maintenance Director

Completion Date: 02/05/2026

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented [redacted] - 04/13/2026)

121a - Unobstructed Egress

5. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

121a - Unobstructed Egress *(continued)*

Description of Violation

On [redacted] at 9:22 AM, snow blocked egress from the home's Secured Dementia Care Unit (SDCU) through the courtyard.

Plan of Correction ***Accept (02/24/2026)***

Correction: Snow removed immediately.

Prevention: Snow removal plan updated.

Monitoring: Maintenance inspections during winter events.

Completion Date: 01/22/2026

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented - 04/15/2026)

187d - Follow Prescriber's Orders

6. Requirements

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

Description of Violation

Resident is prescribed give 1 tablet by mouth nightly. This medication was administered from through at 9:00 AM. Also, this medication was not administered to Resident from through because the medication was not available in the home.

Plan of Correction ***Accept (- 03/10/2026)***

Correction: Medication timing corrected and medication reordered.

Prevention: Medication reorder process reinforced.

Resident s medication order was reviewed and clarified with the prescribing provider.

Medication Administration Record (MAR) was corrected to reflect the correct administration time (nightly).

Pharmacy was contacted to ensure medication availability and confirm refill schedule.

Resident was monitored for any adverse outcomes related to missed or incorrectly timed doses.

Monitoring: Weekly MAR audits for 60 days.

Responsible Party: Program Coordinator/DON

Completion Date: 02/08/2026

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

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented - 04/13/2026)

191 - Resident Right to Refuse

7. 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 , has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Repeat violation et al.

Plan of Correction ***Accept - 03/10/2026)***

Correction: Resident/designee educated and documented.

Prevention: Admission checklist updated.

Monitoring: Quarterly chart audits.

Resident was educated on:

The right to question medications.

The right to refuse medications.

The process for reporting concerns regarding possible medication errors.

Education was documented in the resident record.

If applicable, responsible party notified of resident rights.

Responsible Party: Program Coordinator/DON

Completion Date: 02/06/2026

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented - 04/13/2026)

224a - Preadmission Screen Form

8. Requirements

2600.

224a - Preadmission Screen Form *(continued)*

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 [redacted] was admitted to the home on [redacted]; however, the resident's preadmission screening form was not completed as of [redacted]

Plan of Correction ***Accept ([redacted] 03/10/2026)***

Correction: Screening completed.

Prevention: Admission checklist revised.

Monitoring: Administrator admission review.
The Department's preadmission screening form was completed for Resident [redacted].

Clinical review confirmed that the resident's needs can be met by the services provided by the home.

Documentation placed in the resident's permanent record.

Admission documentation audit initiated for all current residents to ensure compliance.

Responsible Party: Program Coordinator/DON

Completion Date: 02/06/2026

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented [redacted] - 04/13/2026)

227g -Support Plan Signatures

9. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident [redacted] support plan, dated [redacted] was not signed by the assessor.

Plan of Correction ***Accept [redacted] 03/10/2026)***

Correction: Support plan signed.

Prevention: Signature verification audits added.

Monitoring: Quarterly chart reviews.
Resident [redacted] support plan was reviewed.

Required signatures were obtained from:

227g -Support Plan Signatures (continued)

The home representative

The resident and/or resident's designee

Document was properly dated and placed in the resident record.

Audit initiated of all current resident support plans to verify signature compliance.

Responsible Party: Program Coordinator

Completion Date: 02/06/2026

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented 04/13/2026)

231c - Preadmission Screening

10. 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 written cognitive preadmission screening was not completed as of

Plan of Correction ***Accept - 03/10/2026)***

Correction: Screening completed.

Prevention: SDCU admission checklist updated.

Monitoring: Administrator review.

The required written cognitive preadmission screening was completed in collaboration with the resident's physician/appropriate clinical provider.

Documentation placed in the resident's permanent record.

Clinical review confirmed appropriateness of SDCU placement.

Full audit initiated of all current SDCU residents to verify required documentation is present.

Responsible Party: Program Coordinator

Completion Date: 02/06/2026

231c Preadmission Screening *(continued)*

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented - 04/13/2026)

231e - No Objection Statement

11. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident was admitted to the Secure Dementia Care Unit (SDCU) on . The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept - 03/10/2026)***

Correction: Documentation obtained.

Prevention: Added to SDCU admission packet.

Monitoring: Quarterly audits.
Resident and/or designated person were contacted.

Discussion held regarding SDCU placement and appropriateness.

Written documentation obtained confirming no objection to placement.

Documentation placed in resident's permanent record.

Audit initiated of all current SDCU residents to verify non objection documentation is present.

Responsible Party: Move In Coordinator

Completion Date: 02/06/2026

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented - 04/15/2026)

234e - Involvement/Participation

12. Requirements

2600.
234.e. The resident or the resident's designated person shall be involved in the development and the revisions of the support plan.

Description of Violation

Resident s support plan was developed on Neither the resident nor the resident's designated person were involved in the development.

234e - Involvement/Participation *(continued)*

Plan of Correction ***Accept 03/10/2026)***

Correction: Support plan reviewed and updated.

Prevention: Care plan meetings scheduled.
Resident and/or designated person were contacted.

A support plan meeting was conducted (or offered) to review and revise the plan.

Input from the resident/designee was incorporated into the updated support plan.

Participation was documented in the support plan.

Signatures and dates obtained.

Updated plan placed in resident record.

Audit initiated of all current resident support plans to verify documentation of involvement.

Monitoring: Quarterly documentation review.

Responsible Party: Program Coordinator

Completion Date: 02/07/2026

Licensee's Proposed Overall Completion Date: *02/26/2026*

Not Implemented - 04/13/2026)