

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

May 4, 2026

[REDACTED]
BKD CLARE BRIDGE OF DUBLIN, LLC
[REDACTED]
[REDACTED]

RE: BROOKDALE DUBLIN
160 ELEPHANT ROAD
DUBLIN, PA, 18917
LICENSE/COC#: 15121

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/13/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BROOKDALE DUBLIN* License #: *15121* License Expiration: *12/06/2025*
 Address: *160 ELEPHANT ROAD, DUBLIN, PA 18917*
 County: *BUCKS* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *BKD CLARE BRIDGE OF DUBLIN, LLC*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C 2 LP* Date: *08/20/1988* Issued By: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *46* Waking Staff: *35*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal, Complaint, Incident* Exit Conference Date: *11/13/2025*

Inspection Dates and Department Representative

11/13/2025 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *26* Residents Served: *23*

Secured Dementia Care Unit
 In Home: *Yes* Area: *entire home* Capacity: *26* Residents Served: *23*

Hospice
 Current Residents: *3*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *23*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *23* Have Physical Disability: *0*

Inspections / Reviews

11/13/2025 - Full
 Lead Inspector: [REDACTED] Follow Up Type: *POC Submission* Follow Up Date: *12/14/2025*

Inspections / Reviews (*continued*)

12/16/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/09/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 12/21/2025

12/23/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/09/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 01/08/2026

05/04/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/09/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c - Written Incident Report

1. Requirements

2600.

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

Description of Violation

On [REDACTED], Resident [REDACTED] had an unwitnessed fall and was later transferred to the hospital by emergency services. This incident was not reported to the Department until [REDACTED]

Plan of Correction

Accept [REDACTED] - 12/16/2025)

Immediate Action: District Director of Operations (DDO) and District Director of Clinical Services (DDCS) retrained the Executive Director (ED) and Health and Wellness Director (HWD) on community policy and state regulation regarding suspected abuse and timely notification of DHS and AAA on 11/13/2025.

11/12 incident reported to DHS and AAA by District Director of Clinical Services following a phone call with resident's POA. Incident was not reported to DHS within 24 hours.

Training: The ED retrained all associates on the regulation, community policy and requirements for reporting abuse within 24 hours on 12/2/2025.

Ongoing: To assist with ongoing compliance, the ED or designee will review Incident reports daily for three (3) weeks starting on 12/12/25 to confirm DHS report is completed and sent to DHS.

Licensee's Proposed Overall Completion Date: 01/02/2026

Implemented [REDACTED] 05/04/2026)

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

Resident [REDACTED] resided in the home from [REDACTED] through [REDACTED]. Resident [REDACTED] required extensive supervision while in the home per their support plan dated [REDACTED]. The resident's support plan also indicated that they needed extensive assistance ambulating and transferring as they are very unsteady on their own and would often try to walk without their wheelchair. The resident sustained four falls while living in the home. These falls were all unwitnessed per progress notes provided by the home and occurred on [REDACTED] and [REDACTED]. Interviews with staff members indicated that this resident was left unsupervised on several occasions including when [REDACTED] final fall occurred at the home on [REDACTED] due to there only being two direct care staff members on shift. The two staff members on shift left to help one of the four other residents in the home who require two person assists. When staff members returned to the dining room after providing care to another resident, they found Resident [REDACTED] on their back on the floor. They took Resident [REDACTED] to their room to lie down. Emergency services were not called for the resident until the resident's family came into the home and requested they be called due to the resident being found laying with their head at the foot of their bed in tremors with their eyes red and crusted shut. EMS transported Resident [REDACTED] to the hospital. The resident did not return to the home.

42b - Abuse (continued)

Plan of Correction

Directed [REDACTED] - 12/22/2025)

Immediate Action: The ED or designee has placed agency staff in community and HWC will assist with care regularly.

Training: The ED retrained all managers on staffing requirements on 12/9/2025.

Ongoing: The Executive Director and/or designee will continue to monitor staffing hours daily to be sure staffing is appropriate beginning on 12/4/2025 for 4 weeks and then monthly for 2 months. If staffing is not appropriate, the HWD or HWC will cover as needed.

Proposed Overall Completion Date: 01/05/2026

Directed Plan of Correction (12/23/25 [REDACTED]

Immediately, the administrator or designated staff person shall develop and implement a schedule that includes the availability of providing at least one hour per day of personal care services for each mobile resident and two hours per day of personal care services for each resident who has mobility needs. At least 75% of the required personal care service hours will be available during waking hours and additional personal care service staffing hours shall be scheduled to meet the needs of the residents as specified in the resident's assessments, support plans and as needed to safely evacuate the residents in the event of an emergency.

Immediately, the administrator shall review the schedule and residents' assessments and support plans at least weekly to ensure adequate staffing is scheduled.

Starting within 5 days of the receipt of the acceptable plan of correction, the administrator shall interview at least three residents a week for three months and biannually thereafter to ensure no residents are neglected, intimidated, physically or verbally abused, mistreated or disciplined in any way, at any time. Documentation of interviews shall be kept.

Within 15 days of receipt of the accepted plan of correction, all direct care staff, ancillary staff persons, substitute personnel, volunteers and management staff including the administrator shall receive training in abuse reporting and prevention and resident rights.

Directed Completion Date: 01/07/2026

Implemented [REDACTED] - 05/04/2026)

57c - 2 Hours/Day

3. Requirements

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On [REDACTED] and [REDACTED], there were 23 residents in the home, including 23 residents with mobility needs, requiring a total minimum of 46 hours of direct care service. On these dates, only 42 hours of direct care staffing were provided.

Plan of Correction

Directed [REDACTED] - 12/22/2025)

Immediate Action: The ED or designee has placed agency staff in community and HWC will assist with care regularly.

57c 2 Hours/Day (continued)

Training: The ED retrained all managers on staffing requirements on 12/9/2025.

Ongoing: The Executive Director and/or designee will continue to monitor staffing hours daily to be sure staffing is appropriate beginning on 12/4/2025 for 4 weeks and then monthly for 2 months. If staffing is not appropriate, the HWD or HWC will cover as needed.

Proposed Overall Completion Date: 01/05/2026

Directed Plan of Correction (12/23/25 [REDACTED]):

Immediately, the administrator or designated staff person shall develop and implement a schedule that includes the availability of providing at least one hour per day of personal care services for each mobile resident and two hours per day of personal care services for each resident who has mobility needs. At least 75% of the required personal care service hours shall be available during waking hours and additional personal care service staffing hours shall be scheduled to meet the needs of the residents as specified in the resident's assessments, support plans and as needed to safely evacuate the residents in the event of an emergency.

Immediately, the administrator shall review the schedule and residents' assessments and support plans at least weekly to ensure adequate staffing is scheduled.

Directed Completion Date: 01/05/2026

Implemented [REDACTED] - 05/04/2026)

64c - Annual Training

4. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person A, the home's administrator, could not provide proof that any annual training was completed during the 2024 training year.

Plan of Correction

Accept [REDACTED] - 12/22/2025)

Immediate Action: Staff Member A was terminated on [REDACTED]. Operations Specialist/Interim Executive Director was placed at the community on 11/19/25. See attached qualifications. Operations specialist is managing only the operations of the home and following the regulation regarding time required in the building. Regional operations is going through the interview and hiring process with candidates at this time.

Training: The DDO trained the Operations Specialist regulation and requirements relating to the administrator job duties on 12/2/25.

Ongoing: Annual training will be audited quarterly for completion by the Executive Director or designee to be sure meeting the 24 hour requirement to begin upon hiring a new Executive Director.

Licensee's Proposed Overall Completion Date: 12/21/2025

64c - Annual Training (continued)

Implemented (██████ 05/04/2026)

65a - FS Orientation 1st Day

5. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

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

Staff person C, whose first day of work was ████████ did not receive orientation on the following topics: Evacuation procedures; Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable; The designated meeting place outside the building or within the fire-safe area in the event of an actual fire; Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable; The location and use of fire extinguishers; Smoke detectors and fire alarms; Telephone use and notification of emergency services.

Plan of Correction

Directed (██████ 12/23/2025)

Immediate Action: Staff Members B and C were retrained on general fire safety and emergency preparedness by the ED or designee on 12/9/25 and both staff Members B and C signed appropriate paperwork for their employee record. Training: The ED retrained all managers on general fire safety and emergency preparedness on 12/9/25.

Ongoing: Audit of all employee records to be completed by Executive Director and/or designee by 12/31/25. The ED or designee will verify any required training is completed. Executive Director or designee will audit all new employee trainings are completed upon hire. ED will monitor records quarterly to verify orientation on general fire safety and emergency preparedness is completed prior to the first day of work.

Proposed Overall Completion Date: 01/02/2026

65a FS Orientation 1st Day (continued)

Directed Plan of Correction (12/23/25 [REDACTED]):

In addition to the above plan, and to clarify, the administrator shall immediately begin monthly audits of new employee training to ensure orientation topics have been completed for two months, then quarterly thereafter.

Directed Completion Date: 01/02/2026

Implemented [REDACTED] - 05/04/2026)

101j5 - Bedside Table/Shelf

6. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident [REDACTED]'s bed in bedroom [REDACTED]

Plan of Correction

Accept [REDACTED] - 12/23/2025)

Immediate Action: An over the bed table is placed at the bed when the resident is in the bed.

Training: All staff retrained on this regulation and requirements by the Executive Director on 12/2/2025.

Ongoing: To assist with ongoing compliance, the ED or designee will complete audits of six (6) resident rooms per week for four (4) weeks and monthly for three (3) months beginning 12/9/25 to verify compliance.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented [REDACTED] - 05/04/2026)

101j7 - Lighting/Operable Lamp

7. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident [REDACTED] does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction

Accept [REDACTED] 12/23/2025)

Immediate Action: Lamp placed in resident [REDACTED] room next to the bed.

Training: All staff retrained on regulation and requirements by Executive Director on 12/2/2025.

Ongoing: To assist with ongoing compliance, the ED or designee will complete audits of six (6) resident rooms per week for four (4) weeks and monthly for three (3) months beginning 12/9/25 to verify compliance.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented ([REDACTED] - 05/04/2026)

102h - Toilet Paper

8. Requirements

102h Toilet Paper (continued)

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On [REDACTED] at 9:41am, there was no toilet paper for the toilet in the bathroom of Resident # [REDACTED]

Plan of Correction

Accept ([REDACTED] - 12/23/2025)

Immediate Action: Toilet paper placed in resident [REDACTED] bathroom.

Training: All staff retrained on regulation and requirements by Executive Director on 12/2/2025.

Ongoing: To assist with ongoing compliance, the ED or designee will complete audits of six (6) resident rooms per week for four (4) weeks and monthly for three (3) months beginning 12/9/25 to verify compliance.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented [REDACTED] - 05/04/2026)

107d Procedure Emergency Management Agency Submission

9. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been sent to the local emergency management agency since [REDACTED]

Plan of Correction

Accept ([REDACTED] - 12/23/2025)

Immediate Action: Emergency Management Plan was printed out and sent to Bucks County Emergency Management Services via email on 11/21/25 by the ED or designee. The community received confirmation from Bucks County that this Emergency Management Plan was received.

Training: The ED retrained the HWC and Maintenance Director on this regulation and requirements on 12/2/25.

Ongoing: Emergency Management Plan will be updated annually by the Executive Director in January, and sent to Bucks County Emergency Management Services by the ED and/or designee by the end of January beginning 1/31/2026. This will be audited in the state readiness binder every 3 months to be sure updated and received.

Licensee's Proposed Overall Completion Date: 01/02/2026

Implemented [REDACTED] - 05/04/2026)

121a Unobstructed Egress

10. Requirements

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

Description of Violation

On [REDACTED] at 9:34am, a large banner with a stop sign blocked egress from the home's back emergency exit.

Plan of Correction

Accept ([REDACTED] - 12/23/2025)

Immediate Action: Stop sign removed from the door on 11/19/25 by the Executive Director.

121a Unobstructed Egress (continued)

Training: All staff were retrained on 12/2/25 regarding regulation by the ED.

Ongoing: The ED or designee will audit all exits weekly for four (4) weeks and then monthly for three (3) months beginning on 12/9/2025 to verify the egress routes are unobstructed.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented [redacted] - 05/04/2026)

123b - Emergency Procedures Posted

11. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction

Directed [redacted] - 12/23/2025)

Immediate Action: The ED printed the Emergency Manual Plan and placed in a binder.

Training: The ED retrained all staff regarding emergency manual usage and location.

Ongoing: Emergency Manual will be printed and updated annually and staff retrained regarding use and placement of the Emergency Manual by the ED and/or designee. The binder will be monitored quarterly to be sure it is present and available to staff beginning on 12/9/2025.

Proposed Overall Completion Date: 12/21/2025

Directed Plan of Correction (12/23/25 [redacted])

In addition to the above plan of correction, and to clarify, beginning immediately, the administrator shall perform quarterly audits for the presence of the Emergency Procedures to ensure conspicuous and public availability.

Directed Completion Date: 12/21/2025

Implemented [redacted] 05/04/2026)

124 - Notice to Fire Department

12. Requirements

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction

Accept [redacted] - 12/23/2025)

Immediate Action: Letter sent to the local fire department on 11/21/25 by the Executive Director with information and self addressed stamped envelope included for a returned/signed copy.

124 Notice to Fire Department (continued)

Training: The ED retrained the management team including the HWC, Maintenance Manager, Sales Manager, and Dining Manager regarding regulation on 12/2/25

Ongoing: The ED or designee will send a letter to the local fire department with updated/correct numbers and changes to census. This will be monitored and sent by the Executive Director every month if census numbers change beginning on 1/5/2026.

Licensee's Proposed Overall Completion Date: 01/02/2026

Implemented (████) - 05/04/2026)

132d - Evacuation

13. 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

During the fire drill on █████ at 7:26pm, the home did not evacuate all residents of the home. One resident, on hospice but not actively dying, was not evacuated during this drill.

Plan of Correction

Accept (████) - 12/23/2025)

Immediate Action: Fire drill performed on 11/19/25 and all residents were evacuated.

Training: The ED retrained all staff regarding regulation and requirement for evacuation on 12/2/25.

Ongoing: To assist with ongoing compliance, fire drills will be monitored via paper and observation monthly by the Executive director and/or designee for three (3) months beginning on 12/9/2025.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented (████) - 05/04/2026)

183e - Storing Medications

14. 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 █████, a █████ belonging to Resident █████ was observed opened and undated in the home's medication cart. Per manufacturer's instructions, this medication should be discarded 28 days after opening.

On █████ Resident █████ blister pack was observed to have a punctured blister foil with the medication still present in the spot exposing it to contamination or improper sanitation.

183e Storing Medications (continued)

Plan of Correction

Accept [REDACTED] - 12/23/2025)

Immediate Action: Resident [REDACTED] insulin was removed from the cart, discarded, and replaced on 11/12/2025. Resident #6's Lorazepam dosing that was punctured was removed and discarded per policy on 11/12/2025.

Training: Medication Techs, HWC, and clinical specialist were retrained on regulation and requirements by the ED on 12/2/25.

Ongoing: Medication cart audits will be completed weekly for four (4) weeks and monthly for three (3) months starting on 12/9/25 by the Executive Director and/or designee.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented [REDACTED] - 05/04/2026)

185a - Implement Storage Procedures

15. Requirements

2600.

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

Description of Violation

Resident [REDACTED] is prescribed blood glucose monitoring two times per day for [REDACTED]. On the following dates, the glucometer readings in the machine did not match the readings entered on the resident's medication administration record:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

Plan of Correction

Accept [REDACTED] - 12/23/2025)

Immediate Action: Staff were questioned and it was determined that the numbers were just transcribed incorrectly.

Training: Medication Techs, HWC, and clinical specialist were retrained on regulation and requirements by the ED on 12/2/25.

Ongoing: Glucometer audits will be completed weekly for four (4) weeks and monthly for three (3) months by HWC and/or designee starting on 11/24/25.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented [REDACTED] - 05/04/2026)

187b - Date/Time of Medication Admin.

16. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

During the medication cart audit for Resident [REDACTED], several omissions were observed on the resident's electronic medication administration record (MAR) for [REDACTED] by the Department. Resident [REDACTED] MAR was missing proof of

187b - Date/Time of Medication Admin. (continued)

administration for their Depakote Sprinkles, Docusate Sodium and Metoprolol Tartrate on [REDACTED] The Department requested the MAR be printed their records. When the MAR was given back to the Department by Staff Member D, there were no longer any missing initials on the MAR. In an interview with the Department, Staff Member D indicated that they altered the MAR before giving it back to the Department.

Plan of Correction

Accept [REDACTED] - 12/23/2025)

Immediate Action: Audit completed of resident [REDACTED] MAR. Staff Member D was terminated on 11/24/25. ED or designee retrained medication techs on how to check for missed medications at the end of each shift.

Training: Medication Techs, HWC, and clinical specialist were retrained on regulation and requirements by the Executive Director on 12/2/25. Executive Director and clinical specialist trained med techs on the importance of proper documentation and not changing/altering records.

Ongoing: ED or designee will complete MAR audits for three (3) residents weekly for four (4) weeks and monthly for two (2) months starting 12/9/2025.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented [REDACTED] - 05/04/2026)

187d - Follow Prescriber's Orders

17. Requirements

2600.

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

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] - give 25mcg by mouth one time a day for [REDACTED]. This medication was not administered on [REDACTED].

Plan of Correction

Directed [REDACTED] - 12/23/2025)

Immediate Action: Audit completed of resident [REDACTED]'s available medications and orders. Upon investigation the medication was available, but the staff member missed the medication. The med techs were trained on how to identify missed medications at the end of their shift to avoid this moving forward.

Training: All Medication Techs, HWC, and clinical specialist were retrained on regulation and requirements by the Executive Director on 12/2/25.

Ongoing: Missed medication report will be audited by the HWC and/or designee daily for four (4) weeks and monthly for two (2) months beginning on 12/19/2025.

Proposed Overall Completion Date: 01/31/2026

Directed Plan of Correction (12/23/25 [REDACTED]):

In addition to the above plan, beginning within 10 days from the date of the receipt of the acceptable plan of correction, the administrator or designee shall perform audits of both the missed medication reports and MAR to cart audits once per week for two months, and quarterly thereafter.

Within 10 days of the receipt of the acceptable plan of correction, a qualified medication train-the-trainer or

187d - Follow Prescriber's Orders (continued)

practicum observer shall perform at least two medication administration observations per week for two months, and quarterly thereafter for one year.

Directed Completion Date: 01/31/2026

Implemented (████) - 05/04/2026

225c - Additional Assessment

18. Requirements

2600.

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

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

Description of Violation

Resident █████'s most recent assessment, dated █████, does not include that Resident █████ requires a two person assist with transferring in and out of bed and toileting. The assessment also fails to indicate the degree of assistance needed with drinking.

Resident █████ most recent assessment, dated █████ does not include that Resident █████ requires a two person assist with transferring in and out of bed and toileting.

Resident █████ most recent assessment, dated █████ does not include that Resident █████ requires a two person assist with transferring in and out of bed and toileting.

Resident █████'s most recent assessment, dated █████, does not include that Resident █████ requires a two person assist with transferring in and out of bed and toileting.

Plan of Correction

Accept █████ - 12/23/2025

Immediate Action: Resident █████, Resident █████ Resident █████ and Resident █████ RASP updated by the HWC or designee to reflect the 2-person assist required for transfers on 12/12/25.

Training: HWC and clinical specialist trained on regulation and requirements by the executive director on 12/9/25.

Ongoing: An audit of all resident's RASPs with necessary corrections will be completed by the HWC or designee by 12/31/25 and HWC and/or designee will add addendums to resident's RASPs with changes of condition. RASPs will be audited monthly for three (3) months by Executive Director and/or designee beginning on 2/1/2026.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented █████ - 05/04/2026

227g -Support Plan Signatures

19. Requirements

2600.

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

227g -Support Plan Signatures (continued)

Description of Violation

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] - 12/23/2025)

Immediate Action: Resident [redacted] signed support plan on 12/12/2025.

Training: HWC and clinical specialist were retrained on regulation and requirements by Executive Director on 12/9/25.

Ongoing: All RASPs audited for signatures by clinical specialist or designee on 12/12/2025 and appropriate signatures obtained. Twenty five percent of RASPs will be audited monthly for 3 months starting on 12/19/25.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented [redacted] - 05/04/2026)

233b - Lock Manufacturer Statement

20. Requirements

2600.

233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:

- 1. Upon a signal from an activated fire alarm system, heat or smoke detector.
- 2. Power failure to the home.
- 3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The home does not have a statement from the manufacturer of the home's magnetic locking system verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

Plan of Correction

Accept [redacted] - 12/23/2025)

Immediate Action: The ED contacted the magnetic locking system manufacturer for the letter stating that the locks disengage in the event of any of the events identified in the regulation.

Training: Management team were retrained on regulation and requirements by the Executive Director on 12/9/25.

Ongoing: The ED will maintain the manufacturer's letter in the state binder for surveillance and the letter will be updated if there is any change to the community locks. The state binder will be monitored every 3 months for the presence of the letter beginning on 12/31/25.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented [redacted] - 05/04/2026)

233c - Key-Locking Devices

21. Requirements

2600.

233c Key Locking Devices (*continued*)

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

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door to the main lobby of the Secure Dementia Care Unit (SDCU).

Plan of Correction

Accept (████) - 12/23/2025)

Immediate Action: Directions for the use of the lock posted at the doors.

Training: All staff retrained on the regulation and requirements by the Executive Director on 12/2/2025.

Ongoing: The ED or designee will audit door directions weekly for four (4) weeks, and monthly for three (3) months beginning on 12/9/2025 to verify the directions are posted and remain correct.

Licensee's Proposed Overall Completion Date: 01/05/2026

Implemented (████) 05/04/2026)

252 - Record Content

22. Requirements

2600.

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

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

252 - Record Content (*continued*)

24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident [REDACTED] record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction

Accepted [REDACTED] - 12/16/2025)

Immediate Action: Picture obtained of resident [REDACTED] and updated in the chart on 12/2/2025.

Training: All staff were retrained on regulation and requirements by Executive Director on 12/2/2025.

Ongoing: All resident records audited and pictures updated as needed by Executive Director or designee on 12/12/2025. Resident records pictures will be audited annually by Executive Director and/or designee and updated as needed.

Licensee's Proposed Overall Completion Date: 12/13/2025

Implemented [REDACTED] - 05/04/2026)