

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

April 13, 2026

[REDACTED]
SNH PENN TENANT LLC

[REDACTED]
C/O INTEGRACARE CORP
[REDACTED]

RE: EXTON SENIOR LIVING
600 NORTH POTTSTOWN PIKE
EXTON, PA, 19341
LICENSE/COC#: 14510

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/17/2025, 11/18/2025 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: *EXTON SENIOR LIVING* License #: *14510* License Expiration: *01/01/2026*
 Address: *600 NORTH POTTSTOWN PIKE, EXTON, PA 19341*
 County: *CHESTER* Region: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SNH PENN TENANT LLC*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *05/30/2000* Issued By: *Commonwealth of PA L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *92* Waking Staff: *69*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *11/18/2025*

Inspection Dates and Department Representative

11/17/2025 - On-Site: [REDACTED]
 11/18/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *100* Residents Served: *64*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Life Stories* Capacity: *32* Residents Served: *19*

Hospice
 Current Residents: *9*

Number of Residents Who:
 Receive Supplemental Security Income: *NA* Are 60 Years of Age or Older: *64*
 Diagnosed with Mental Illness: *30* Diagnosed with Intellectual Disability: *1*
 Have Mobility Need: *28* Have Physical Disability: *NA*

Inspections / Reviews

11/17/2025 Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/21/2025*

01/05/2026 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *01/15/2026*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/10/2026*

Inspections / Reviews *(continued)*

01/12/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/15/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 01/15/2026

04/13/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/15/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

17 - Record Confidentiality

2. Requirements

2600.

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

Description of Violation

On [REDACTED] at approximately 10:10am, staff communication logs and resident shower and skin integrity logs were unlocked, unattended, and accessible in a cabinet in the dining room.

Plan of Correction

Accept ([REDACTED] - 01/05/2026)

17

Secure Resident Records

Action Plan: Ensure all resident records are securely stored.

Steps:

- Remove all records from accessible areas
- Store all logs and records in a locked room or cabinet
- Conduct a staff meeting to remind all memory care team members about data privacy and compliance requirements.

Responsible Party: Memory Care Director(or designee)

Time line: Completed 11/19/2025

Immediate Staff Training on Confidentiality

Action Plan: Educate Memory Care staff on the importance of maintaining resident record confidentiality.

Steps:

- Organize a mandatory memory care staff training session regarding confidentiality protocols.

Responsible Party: Memory Care Director (or designee)

Time line: Completed 11/19/2025

Long Term Actions

Regular Confidentiality Audits

Action Plan: Implement a system of audits to regularly monitor the secure storage of resident records.

Steps:

- Develop and complete a daily record confidentiality audit checklist for 90 days .

Responsible Party: Memory Care Director (or designee)

Time line: Daily for 90 days beginning 11/19/2026

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

Implemented ([REDACTED] - 04/13/2026)

25b - Contract Signatures

4. Requirements

2600.

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

25b - Contract Signatures (continued)

Description of Violation

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

Plan of Correction

Accept [REDACTED] 01/05/2026)

25b

Action Plan: Ensure all resident-home contracts are fully executed as required by regulations.

Steps:

Identify and retrieve the incomplete contract for resident #2 immediately.

Obtain/attempt to get signature from resident

Responsible Party: ASD

Time line: Completed by 11.20.2025

Staff Training on obtaining signature/giving resident the option

Educate Marketing team (Community Relations Director) and Administrative Services Director on the regulatory requirements for contract execution to prevent future omissions.

Conduct a training session for the Administrative Service Director and Community Relations Director (Marketing team) on the contract signing process and legal requirements.

Responsible Party: Executive Operations Officer or Designee

Time line: Completed by 11.20.2025

Long Term Actions

1. Ensure no other resident contracts are missing signatures or other required elements.

2. Perform an audit of all resident-home contracts to identify any additional discrepancies. Company has switched to electronic signing to ensure compliance. Audit by 12/31/2025 performed by ASD or designee

Obtain missing signatures for compliance by January 31, 2026, performed by ASD or designee

Responsible Party: Administrative Services Director or Designee

Time line: Complete by 12.31.2025

Executive Director or designee will audit all new resident records to ensure paperwork is signed for 90 days beginning 11/24/2025.

Timeline: Weekly for 90 days beginning 11.24.2025

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [REDACTED] - 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 [REDACTED] from 7a-7pm, 64 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid.

On [REDACTED], from 7am-7pm, 64 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid.

On [REDACTED], from 7a-8am, 64 residents were present in the home. During this time no staff persons were present

63a - First Aid/CPR Training (continued)

in the home who were certified in first aid.

Repeat Violation [REDACTED]

Plan of Correction

Accept [REDACTED] - 01/05/2026)

63a

Immediate Staff Certification Update

Action Plan: Ensure adequate staffing levels with certified personnel

Steps:

- Identify all current staff and their certification status.
- First aide training scheduled for 12/30/2025 at 10am.
- Confirm staff attendance and certification completion.

Responsible Party: ASD, RWD

Time line: 12/31/2025

Communicate and Document Staffing Requirements

Action Plan: Enhance communication and documentation regarding staffing regulations

Steps:

- Schedule created ensuring the minimum required certified staff are present based on current resident numbers.
- First Aid training requirements, classes are being scheduled to keep compliance.
- Invitation to attend sent to all staff through OnShift on 12/22/2025
- Post a visible staffing requirement notice in staff area for ongoing reference.

Responsible Party: Administrative Services Director(or designee)

Time line: On or before 12/31/2025

Long Term Actions

Routine Staff Training and Certification Renewal Program

Action Plan: Maintain consistent compliance with staffing certification requirements

Steps:

- Establish a regular schedule for CPR and First Aid certification availability to ensure renewal every two years.
- Partner with a certified training provider for on-site certification courses.
- Initiate a tracking system to notify staff of recertification deadlines well ahead.

Responsible Party: ASD, RWD (or designee)

Time line: 12/31/2025

Licensee's Proposed Overall Completion Date: 12/31/2025

Implemented [REDACTED] 04/13/2026)

65g - Annual Training Content

7. Requirements

2600.

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

65g - Annual Training Content (continued)

Description of Violation

Staff person A did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert during training year January 2024 to December 2024.

Staff person B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert during training year January 2024 to December 2024.

Plan of Correction

Accepted (redacted) - 01/12/2026

65g

Short Term Actions

Conduct Immediate Fire Safety Training

Action Plan: To ensure Staff persons A and B receive the necessary fire safety training.

Steps:

- Schedule an on-site fire safety training session led by a certified fire safety expert within the next 5 days.
- Inform Staff persons A and B of the training requirement and ensure their attendance.
- Document the completion of the training session for each participating staff member.
- Submit documentation of completed training

Responsible Party: Safety Maintenance Engineer

Time line: Completed 11.19.2025

Verify All Staff Training Records

Action Plan: To confirm all current staff have completed required fire safety training.

Steps:

- Review training records for all staff to identify any others lacking required fire safety training.
- Compile a list of staff requiring immediate training based on this review.
- Schedule necessary training for identified staff with a certified fire safety expert.
- Update training records to reflect current compliance status.

Responsible Party: Administrative Services Director

Time line: Completed 12.18.2025

Long Term Actions

Annual Fire Safety Training Program Implementation

Action Plan: Establish a reliable annual schedule for fire safety training.

Steps:

- SME and ASD are trained as certified fire safety experts
- Develop an annual training calendar with scheduled sessions led by certified experts.
- Ensure all newly-hired staff receive training within the first two days of employment during general orientation.

Responsible Party: Administrative Services Director (or designee)

Time line: 1.31.2026

Licensee's Proposed Overall Completion Date: 01/08/2026

Implemented (redacted) 04/13/2026

85e - Trash Outside Home

8. Requirements

2600.

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

Description of Violation

On [REDACTED] at 9:36am, the trash bins were left uncovered and filled with trash, a bag of trash, plywood, a mattress headboard and an out of order icecream machine was also observed outside the home.

Plan of Correction

Accept [REDACTED] - 01/05/2026)

85e

Immediate Trash Removal and Bin Coverage

Action Plan: Ensure all trash bins are covered and outside areas are cleared of unnecessary items.

Steps:

- Conduct a full inspection of the outside areas to identify all uncovered trash bins and misplaced items.
- Immediately cover all trash bins and remove non-bin trash items such as the bag of trash, plywood, mattress headboard, and ice cream machine.
- Provide all maintenance and janitorial staff with immediate instructions on proper trash management procedures.

Responsible Party: Safety Maintenance Engineer (or designee)

Time line: 11/24/2025

Long Term Actions

Routine Inspections and Monitoring

Action Plan: Maintain compliance with trash regulations through regular oversight.

Steps:

- Implement a weekly inspection routine to check for trash management compliance, focusing on bin coverage and contents. Routine checks logged weekly for 90 days

Responsible Party: Safety Maintenance Engineer (or designee)

Time line: Weekly for 90 days beginning 11/24/2025

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

Implemented [REDACTED] - 04/13/2026)

86b Bathroom

9. 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 vent is inoperable and there is no window in the bathroom.

Plan of Correction

Accept [REDACTED] - 01/05/2026)

86b

Repair Ventilation System

Action Plan: Restore proper ventilation to the bathroom in room [REDACTED].

Steps:

86b - Bathroom (continued)

- Safety Maintenance Engineer immediately replaced inoperable exhaust fan in room [REDACTED]
- Fan is working properly through a post-repair inspection.

Responsible Party: Maintenance Supervisor(or designee)

Time line: Completed 11/20/2025

- Implement a routine check schedule for maintenance staff to identify similar issues in other bathrooms. Audit weekly for 90 days

Responsible Party: Safety Maintenance Engineer (or designee)

Time line: Completed 11/20/2025

Long Term Actions

Implement Routine Ventilation Check Protocols

Action Plan: Prevent future occurrences of inoperable ventilation systems.

Steps:

- Develop a checklist for routine inspections of ventilation systems in all facility bathrooms. Audit weekly for 90 days
- Incorporate this checklist into the monthly maintenance routine (TELS) electronic tracking system.

Responsible Party: Maintenance Engineer (or designee)

Time line: Weekly for 90 days beginning 11/20/2025

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

Implemented [REDACTED] - 04/13/2026)

88a - Surfaces

10. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On [REDACTED] at approximately 9:33am, a large brown stain that appeared to be water damage was observed on the ceiling tile located near the serving exit in the dining room.

On [REDACTED] at approximately 9:34am, paintings and piles of loose paper were stored on the elevator motor, in the elevator room.

On [REDACTED] at approximately 9:39am, the ceiling tile in the laundry room behind the dryer was bulging, stained and flaking at the bottom.

On [REDACTED] at approximately 11:20am, a surge protector located under the temporary front desk station was observed with duct tape covering two outlets on the surge protector.

88a - Surfaces (continued)

Plan of Correction

Accepted [REDACTED] - 01/05/2026)

88a

*Short Term Actions**Immediate Identification and Repair of Ceiling and Electrical Hazards**Action Plan: To eliminate immediate safety hazards and restore cleanliness and structural integrity.**Steps:*

- *Inspect the stained and bulging ceiling tiles in the dining room and laundry room for underlying water damage causes.*
- *Remove and replace the damaged ceiling tiles to eliminate visible stains and flaking.*
- *Inspect and replace the hazardous surge protector under the temporary front desk station.*
- *Ensure safe storage of items in the elevator room.*

*Responsible Party: Safety Maintenance Director (or designee)**Time line: Completed 11/21/2025**Staff Training on Safety and Cleanliness**Action Plan: To educate Safety Maintenance Engineer on maintaining facility safety and cleanliness standards.**Steps:*

- *Conduct a training session covering the identification and reporting of structural and electrical hazards.*
- *Provide guidelines on appropriate storage techniques to prevent clutter and potential fire hazards.*
- *Distribute educational materials that outline the regulations regarding cleanliness and maintenance (Regulation 2600.88.a).*

*Responsible Party: Executive Operations Officer (or designee)**Time line: Completed 11/21/2025**Enhanced Documentation and Reporting System**Action Plan: To improve the reporting and documentation of facility hazards and repairs.**Steps:*

- *Revise the current reporting form to include specific fields for structural and electrical issues.*
- *Use TELS for tracking maintenance requests and their completion status.*

*Responsible Party: Safety Maintenance Director (or designee)**Time line: Completed 11/21/2025**Long Term Actions**Regular Facility Inspections**Action Plan: To ensure ongoing compliance with safety and cleanliness standards.**Steps:*

- *Establish Weekly Inspections for 60 days*
- *Include checks for water damage, ceiling integrity, and proper storage in the inspection routine.*
- *Document findings and initiate repair and maintenance requests as needed.*

*Responsible Party: Safety Maintenance Director (or designee)**Time line: Weekly for 60 days beginning 11/24/2025***Licensee's Proposed Overall Completion Date: 12/19/2025**

Implemented [REDACTED] - 04/13/2026)

89b - Hot Water Temperature

11. Requirements

89b - Hot Water Temperature (continued)

2600.

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

Description of Violation

On [redacted] at 10:02am, the hot water temperature in the bathroom of room [redacted] for Resident [redacted], measured 123.2 degrees Fahrenheit.

Repeat Violation [redacted]

Plan of Correction

Accept [redacted] - 01/05/2026)

89b

Immediate Temperature Adjustment

Action Plan: Reduce the water temperature to comply with regulations immediately.

Steps:

- Conduct an immediate check of the hot water temperature in room [redacted] and adjust the thermostat on the water heater to ensure it does not exceed 120°F.
- Document the temperature readings after adjustment to confirm compliance. Completed 11/17/2025 (inspector present)

Responsible Party: Safety Maintenance Director (or designee)

Time line: Completed 11/17/2025

Staff Training on Temperature Monitoring

Action Plan: Ensure staff are trained to monitor and regulate water temperatures efficiently.

Steps:

- Have ITLandis or similar (hot water system vendor) conduct a training session for all maintenance staff on monitoring recently installed water system temperatures and emergency procedures for temperature excesses.
- Implement a sign-off sheet for employees to acknowledge completion of the training.

Responsible Party: Administrator (or designee)

Time line: 12/10/2025

Long Term Actions

Regular Monitoring and Quality Assurance

Action Plan: Establish a system for regular water temperature checks to prevent future violations.

Steps:

- Safety Maintenance Director will do daily checks with documentation for 30 days and then continue with weekly checks as part of regular monitoring
- Create a log for documenting each temperature check, adjustments, and corrective actions taken as needed.

Responsible Party: Safety Maintenance Director (or designee)

Time line: 11/17/2025

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

Implemented [redacted] - 04/13/2026)

102h - Toilet Paper

12. Requirements

2600.

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

102h - Toilet Paper (continued)

Description of Violation

On [redacted] at 10:02am, there was no toilet paper for the toilet in the bathroom located in room [redacted] for Resident [redacted]

Plan of Correction

Accept [redacted] 01/05/2026)

102h

Restock Toilet Paper

Action Plan: Ensure immediate availability of toilet paper in room [redacted]

Steps:

- Verify all bathrooms, including room [redacted], are restocked with toilet paper. Done immediately
- Check all storage supplies and note any shortages in toilet paper.

Responsible Party: Hospitality Executive Associate (or designee)

Time line: Completed 11/17/2025

Staff Training on Supplies Check

Action Plan: Ensure staff are aware of their responsibilities regarding daily supplies checking.

Steps:

- Conduct a training session focusing on the importance of daily supplies checks.
- Provide a checklist to staff for weekly random bathroom supply inspections for 90 days.

Responsible Party: Hospitality Executive Associate (or designee)

Time line: Completed 11/18/2025

Long Term Actions

Monthly Supply Audits

Action Plan: Regularly monitor and ensure all restrooms are continually stocked with necessary supplies.

Steps:

- Implement a monthly audit process for restroom supplies for 90 days.
- Assign staff to conduct weekly random bathroom checks and report findings for 90 days.

Responsible Party: Hospitality Executive Associate (or designee)(or designee)

Time line: Implemented 11/17/2025

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

Implemented [redacted] - 04/13/2026)

102i - Soap Dispenser

13. Requirements

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There was no soap in the soap dispenser in room [redacted] for Resident [redacted]

Plan of Correction

Accept [redacted] - 01/05/2026)

102i

Restock Soap Dispenser

Action Plan: Ensure immediate availability of soap in room [redacted].

102i - Soap Dispenser (continued)

Steps:

- Verify all bathrooms, including room [REDACTED], are soap dispenser refilled. Done immediately
- Check all storage supplies and note any shortages in soap dispensers.

Responsible Party: Hospitality Executive Associate (or designee)

Time line: Completed 11/19/2025

Staff Training on Supplies Check

Action Plan: Ensure staff are aware of their responsibilities regarding daily supplies checking.

Steps:

- Conduct a training session focusing on the importance of daily supplies checks.
- Provide a checklist to staff for weekly random bathroom supply inspections for 90 days.

Responsible Party: Hospitality Executive Associate (or designee)

Time line: Completed 11/18/2025

Long Term Actions

Monthly Supply Audits

Action Plan: Regularly monitor and ensure all restrooms are continually stocked with necessary supplies.

Steps:

- Implement a monthly audit process for restroom supplies for 90 days.
- Assign staff to conduct weekly random bathroom checks and report findings for 90 days.

Responsible Party: Hospitality Executive Associate (or designee)(or designee)

Time line: Implemented 11/17/2025

Licensee's Proposed Overall Completion Date: 12/20/2025

Implemented [REDACTED] - 04/13/2026)

103f - Refrigerator/Freezer Temps

14. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On [REDACTED] at 9:46am the temperature in the refrigerator and freezer was 45 degrees Fahrenheit.

Plan of Correction

Accept [REDACTED] - 01/05/2026)

103f

Temperature Adjustment

Action Plan: To ensure refrigerators and freezers are operating within the required temperature range.

Steps:

- Maintenance and safety Director immediately discarded/replaced faulty refrigerator which was not in use.
- Monitor temperatures daily in refrigerator and freezer
- Dispose of any potentially unsafe perishable food items that may have been compromised.

Responsible Party: Maintenance Director(or designee)

Time line: Completed 11/19/2025

Temperature Monitoring Equipment Installation

Action Plan: To ensure continuous and accurate temperature monitoring.

103f - Refrigerator/Freezer Temps (continued)

Steps:

- Ensure thermometers are in refrigerators and freezers.
- Monitor temperatures daily for both refrigerator and freezer assuring at or below 40 degrees and at or below zero degrees respectively.

Responsible Party: Maintenance Director/Activities Director (or designee)

Time line: 11/20/2025

Immediate Training and Communication

Action Plan: To avoid recurrence of temperature oversight.

Steps:

- In-service with Maintenance Director and Activities Director regarding maintaining temperature logs (11/20/2025)
- Communicate the violation incident to staff in a communication via OnShift to ensure awareness and review potential consequences of non-compliance with food storage regulations. Sent 12/23/2025

Responsible Party: Dietary Experience Director (or designee)

Time line: 12/23/2025

Long Term Actions

Ongoing Temperature Audits

Action Plan: To regularly verify and ensure compliance with temperature regulations.

Steps:

- Implement a daily log for both the refrigerator and freezer temperatures.
- Report any failed temperatures to Administrator and Dining Experience Director

Responsible Party: Activity Director (or designee)

Time line: Implemented Daily Log 11/20/2025

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

Implemented [redacted] 04/13/2026)

121a - Unobstructed Egress

16. 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 9:35am, trash cans and containers of rug cleaner blocked egress from the home's exit door located on the right side, behind the kitchen.

Plan of Correction

Accepted [redacted] - 01/05/2026)

121a

Short Term Actions

Remove and Relocate Trash Cans and Rug Cleaner

Action Plan: Ensure all egress routes are immediately unobstructed to comply with safety regulations.

Steps:

- Inspect and ensure all egress routes, including stairwells, are free from obstructions.
- Immediately remove the cleaning cart from the Trash Cans and Rug Cleaner.

Responsible Party: Safety & Maintenance Engineer (or designee)

121a - Unobstructed Egress (continued)

Time line: Completed on 11.19.2025

Conduct Staff Training on Obstruction Prevention

Action Plan: Educate housekeeping staff on the importance of keeping egress routes unobstructed at all times.

Steps:

- Organize a training session focusing on the importance of unobstructed egress routes.
- Explain the locations where cleaning carts and other items can be safely stored.

Responsible Party: Safety & Maintenance Engineer (or designee)

Time line: Completed 11.19.2025

Long Term Actions

Implement Immediate Monitoring Protocols

Action Plan: Establish a system to regularly verify the clearance of egress routes.

Steps:

- Weekly inspections of all egress routes by Safety Maintenance Engineer or designated staff for 90 days
- Use a checklist to ensure all egress paths, including stairwells, are unobstructed.

Responsible Party: Safety & Maintenance Engineer (or designee)

Time line: Completed 11.19.2025

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

Implemented [redacted] - 04/13/2026)

124 - Notice to Fire Department

18. 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] - 01/05/2026)

124

Send Immediate Notification to Fire Department

Action Plan: To ensure the local fire department is informed about the home's address, bedroom locations, and assistance needed for evacuation.

Steps:

- Draft a formal written notification including the home's address, the locations of bedrooms, and the specific assistance required during evacuation.
- Send the written notification via e-mail to the local Fire Marshall.
- Retain sent e-mail as proof of notification. Mobility listing was sent on October 31, 2025 but couldn't provide adequate proof at time of inspection

Responsible Party: Administrator (or designee)

Time line: Completed 11/19/2025

Review and Update Emergency Communication Policies

Action Plan: To reinforce and update policies for emergency communication and documentation processes.

Steps:

124 - Notice to Fire Department (continued)

· Protocol changed to reflect Administrator (or Designee) will send updated mobility list to Fire Marshall every Friday or with any mobility or census change.

Responsible Party: Administrator (or designee)

Time line: Completed 12/19/2025

Long Term Actions

Implement Mobility Needs notification to Fire Marshall

Action Plan: To ensure continuous compliance with regulatory requirements and proper documentation.

Steps:

· Administrator (or Designee) will send via e-mail, updated mobility list to Fire Marshall every Friday or with any mobility or census change.

· Administrator will solely be responsible for retention of emails for proof of communicating

· Fire Marshall notified of new weekly protocol and Mobility Needs on 12/19/2025 via e-mail

· Document findings of each review and implement any necessary changes in procedures immediately.

Responsible Party: Administrator (or designee)

Time line: Weekly communication beginning 12/19/2025

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

Implemented [redacted] - 04/13/2026)

131f - Fire Extinguisher Inspection

19. 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 mail area and the fire extinguisher near the administrator office on the first floor has not been inspected by a fire safety expert since 10/2024.

The fire extinguisher located in the hall on the second floor has not been inspected by a fire safety expert since 10/2024.

Plan of Correction

Accept [redacted] 01/05/2026)

131f

Immediate Fire Extinguisher Inspection

Action Plan: To ensure all fire extinguishers are inspected and approved as required by regulations.

Steps:

· Contact a certified fire safety expert to inspect all fire extinguishers in the facility.

· Schedule the inspection within the next 7 days and obtain the expert's approval and date of inspection on the extinguishers.

· Document the completed inspections

Responsible Party: Safety Maintenance Director (or designee)

Time line: Completed 11/21/2025

Long Term Actions

Implement Fire Safety Monitoring System

131f - Fire Extinguisher Inspection (continued)

Action Plan: To establish a long-term system for monitoring fire safety compliance and ensuring timely inspections.

Steps:

- Safety Maintenance Director will use TELS as a compliance reminder for monthly Fire Extinguisher Inspections and date/initial the back of the tag on each.
- Place digital tracking system in Administrator's and Safety Maintenance Engineer's Outlook Calendars with alerts for Inspection deadlines

Responsible Party: Administrator (or designee)

Time line: Completed 11/24/2025

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

Implemented [redacted] - 04/13/2026)

141b1 - Annual Medical Evaluation

20. Requirements

2600.

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

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted].

Plan of Correction

Accept [redacted] - 01/05/2026)

141b1

Immediate Resident Medical Evaluation

Action Plan: To ensure Resident [redacted] receives an immediate medical evaluation and is compliant with annual medical evaluations.

Steps:

- Resident [redacted] did not have a medical evaluation before 8/6/2025 due to [redacted] physician passing. [redacted] evaluation was completed on 10/9/2025 once a new primary care physician was in place. The next scheduled annual evaluation is in the system and will be completed on or before 10/9/2026.
- Confirmed annual DME is Documented and the completion of the medical evaluation in Resident 3's records.
- Verify the compliance with the annual medical evaluation requirement for all residents.

Responsible Party: Resident Wellness Director (or designee)

Time line: Completed 11/19/2025

Staff Training on Annual Medical Evaluations

Action Plan: To educate staff on the importance and scheduling of annual medical evaluations.

Steps:

- Conduct a training session for Resident Wellness Director on the importance of timely annual medical evaluations.
- Provide with a checklist and schedule for tracking upcoming medical evaluations.
- Review current policies and ensure they include procedures for scheduling annual medical evaluations.
- Evaluate understanding and provide additional resources if needed.

Responsible Party: Wellness & Operations Specialist(or designee)

141b1 - Annual Medical Evaluation (continued)

Time line: Completed on 12/18/2025

Long Term Actions

Implement a Medical Evaluation Tracking System

Action Plan: All new residents will have their medical evaluation dates entered into our electronic system identifying annual due dates.

Steps:

- Follow the current medical evaluation tracking system.
- Continuously monitor the system's effectiveness and make adjustments as necessary.
- Chart audits to be completed monthly for 90 days by Resident Wellness Director or LPN Supervisor to ensure compliance.

Responsible Party: Resident Wellness Director (or designee)

Time line: Monthly for 90 days beginning 12/18/2025

Licensee's Proposed Overall Completion Date: 12/22/2025

Implemented [redacted] 04/13/2026)

162c - Menus Posted

21. 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] was posted. However, week of [redacted] was not posted.

Plan of Correction

Accept [redacted] - 01/05/2026)

162c

Immediate Menu Posting and Review

Action Plan: Ensure compliance with menu posting requirements by posting the menu for the week of 11/23/2025-11/29/2025 immediately.

Steps:

- Identify the menu for the week of 11/23/2025-11/29/2025 within the existing planning documents.
- Post the identified menu in a conspicuous and public place in the home.
- Substitution Menu will be posted and made visible to all residents on the menu board.
- Verify the visibility and correctness of the posted menu immediately after posting.

Responsible Party: Dining Experience Director

Timeline: 11/19/2025

Immediate Staff Briefing

Action Plan: Inform staff about the importance of compliance with menu posting requirements and immediate corrective actions.

Steps:

- Conduct an in-service meeting with Lead Cook responsible staff to communicate the importance of menu

162c Menus Posted (continued)

posting compliance.

- Highlight the recent compliance issue as a learning opportunity for the Lead Cook.
- Discuss the immediate actions taken and emphasize the importance of compliance checks.

Responsible Party: Dining Experience Director

Timeline: Completed 12/1/2025

Long Term Actions

Implement Menu Planning and Monitoring System

Action Plan: Prevent future occurrences of menu posting non compliance by establishing a robust system.

Steps:

- Develop a centralized calendar log that tracks menu planning and posting dates.
- Implement daily checks and updates within the calendar to ensure posting is completed timely for 90 days.
- Designate specific staff roles responsible for menu posting and compliance monitoring.

Responsible Party: Dining Experience Manager or Lead Cook

Timeline: 12/1/2025

Staff Training and Policy Update

Action Plan: Ensure long term compliance through staff education and updated posting policies.

Steps:

- Schedule training sessions for Lead Cook to reinforce the regulations surrounding menu preparation and posting.

Responsible Party: Dining Experience Director

Timeline: Completed 12/1/2025

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

Implemented [redacted] - 04/13/2026)

162e - Menu Changes

22. Requirements

2600.

162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On [redacted], turkey tetrazzini with an alternative of pizza were listed on the menu for the lunch meal. Fried shrimp, crabcake and coleslaw with an alternative of chicken salad on a croissant was served instead. No notice was provided to the residents in advance of the meal.

Plan of Correction

Accept [redacted] - 01/05/2026)

162e

Rapid Notification Protocol Implementation

Action Plan: Ensure residents are informed of menu changes timely.

Steps:

- Develop a protocol for rapid notification of menu changes.
- Notify residents immediately if a menu change occurs, using public announcements and written notices on the bulletin board.
- Ensure Lead Cook is trained on the importance of informing residents and where to post changes.

162e - Menu Changes (continued)

Responsible Party: Dining Experience Director

Timeline: Completed 12/1/2025

Staff Training on Compliance

Action Plan: Train staff on compliance with menu posting regulations.

Steps:

- Conduct a training session on regulatory requirements for posting menu changes.

Responsible Party: Dining Experience Director

Timeline: Completed 12/1/2025

Long Term Actions

Menu Posting Policy Review

Action Plan: Review and update policies for posting menu changes.

Steps:

- Audit Substitution log/posting protocol daily for 30 days for posting menu changes for compliance with 2600.162.e.
- Substitution Logbook will be made available for all cooks.
- When there is a substitution, it will be posted along with the weekly menu .

Responsible Party: Dining Experience Director

Timeline: Daily for 30 days beginning 12/1/2025

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

Implemented [redacted] - 04/13/2026)

181c - Self-administration Assessment

23. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident [redacted] self-administers medications to include Albuterol inhaler; however, Resident [redacted] has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction

Accept [redacted] - 01/12/2026)

181c

Immediate Action Plan: To ensure Resident [redacted] medications removed from room.

Steps:

- Medications removed from Residents Room
- Review/Training of regulation 2600.181.c with Resident Wellness Director and Lead Supervisor LPN.

Responsible Party: Administrator (or designee)

Time line: 11/19/2025

Staff Training on Compliance

Action Plan: To ensure staff understand the requirements for resident medication self-administration assessments.

Steps:

181c - Self-administration Assessment (continued)

· Review/Training with Resident Wellness Director and Medication Techs conducted on 12/2/2025 by Wellness & Operations Specialist including resident assessment requirements related to medication self-administration and not leaving medications in rooms

· Additional Review/Training of Resident Wellness Director conducted on 12/18/2025 by Wellness & Operations Specialist including resident assessment requirements related to medication self-administration.

Responsible Party: Wellness & Operations Specialist (or designee)

Time line: Completed 12/18/2025

Communication and Documentation Update

Action Plan: To inform Residents and Families of protocols including OTC and CAM

· Administrator to send out communication to Residents and families regarding the protocols of residents having medications

including OTC and CAM in their rooms. Sent 12/5/2025

Responsible Party: Administrator (or designee)

Time line: Completed on 12/5/2025

Long Term Actions

Periodic Assessment Review

Action Plan: To ensure ongoing compliance with medication self-administration assessments.

Steps:

· Implement a review schedule for resident medication self-administration assessments quarterly.

· Resident Care and Housekeeping have been instructed to immediately report to supervisor any medications found for any resident who has not been determined to safely self administer medications.

· In-service scheduled on 12/30/2025 for all wellness staff on self-medicator protocols and medication in rooms

· Self medication protocols including OTC and CAM will be reviewed monthly during Resident Council starting January 2026

· Incorporate assessment review results into Quality Assurance (SQIRT) meetings beginning at January 15, 2026 meeting.

Responsible Party: Resident Wellness Director (or designee)

Time line: 1/15/2026

Licensee's Proposed Overall Completion Date: 01/08/2026

Implemented (████) - 04/13/2026)

181f - Record of Medication

24. Requirements

2600.

181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering █████ medication.

Description of Violation

On █████, Resident █████ record did not include a current list of medications. The list in the resident's record did not include over the counter █████.

181f - Record of Medication (continued)

Plan of Correction

Accept [redacted] - 01/12/2026)

181f

Record of Medication

Action Plan: Ensure all residents' medication records are current and complete.

Steps:

- Conduct an immediate audit of all self-administering residents' medication records to ensure they include all prescription, CAM, and OTC medications.
- Verify each resident's medications against their current list in their records.
- Update any missing or outdated medication information in the records.

Responsible Party: Resident Wellness Director (or designee)

Time line: 11/24/2025

Staff Retraining on Documentation

Action Plan: Improve staff accuracy in documentation of medication records.

Steps:

- Conduct a mandatory training of Resident Wellness Director, Lead Supervisor LPN and Med Techs with session focused on the importance of accurate medication record documentation, emphasizing OTC, CAM, and prescription entries.
- Administrator to send out communication to Residents and families regarding the protocols of residents having medications including OTC and CAM in their rooms and self-medicating residents to inform wellness of any medication changes. Sent 12/5/2025

Responsible Party: Wellness & Operations Specialist(or designee)

Time line: Completed on 12/18/2025

Long Term Actions

Monthly Medication Record Review

Action Plan: Maintain ongoing accuracy and completion of medication records.

Steps:

- Self-administering residents' to be assessed quarterly to be in compliance
- Resident Wellness Director (or designee) will meet with Self-administering residents' to review medications, OTC and CAM monthly for 3 months to ensure the current medication list is updated in the resident record.

Responsible Party: Resident Wellness Director (or designee)

Time line: Monthly for 3 months 12/18/2025

Licensee's Proposed Overall Completion Date: 01/08/2026

Implemented ([redacted] 04/13/2026)

183b - Meds and Syringes Locked

25. 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.

183b - Meds and Syringes Locked (*continued*)**Description of Violation**

On [REDACTED] at 9:42am, [REDACTED] and [REDACTED] cream was unlocked, unattended, and accessible in room [REDACTED], Resident [REDACTED] has not been assessed as able to self-administer medications.

On [REDACTED] at 10:28am, two bottles of [REDACTED] observed on bedside table and four bottles of [REDACTED] observed in the bathroom were unlocked, unattended and accessible in room [REDACTED] Resident [REDACTED] has not been assessed as able to self-administer medications.

Plan of Correction

Accept ([REDACTED] 01/12/2026)

183b

Secure Unlocked Medications

Action Plan: To ensure Resident's [REDACTED] and [REDACTED] are evaluated for the ability to self-administer medications.

Steps:

- All unlocked medications in room [REDACTED] and room [REDACTED] have been removed.
- Conducted a check in all resident rooms to ensure no other medications are present.

Responsible Party: Resident Wellness Director(or designee)

Time line: 11/19/2025

Staff Training on Compliance

Action Plan: To ensure staff understand the requirements for resident medication self-administration assessments.

Steps:

- Review/Training of Resident Wellness Director and Lead Supervisor LPN conducted on 12/2/2025 by Wellness & Operations Specialist including resident assessment requirements related to medication self-administration and not leaving medications in rooms

Responsible Party: Wellness & Operations Specialist (or designee)

Time line: Completed 12/2/2025

Communication and Documentation Update

Action Plan: To inform Residents and Families of protocols including OTC and CAM

- Administrator to send out communication to Residents and families regarding the protocols of residents having medications

including OTC and CAM in their rooms. Completed 12/5/2025

Responsible Party: Administrator (or designee)

Time line: Completed on 12/5/2025

*Long Term Actions**Periodic Assessment Review*

Action Plan: To ensure ongoing compliance with medication self-administration assessments.

Steps:

- Resident medication self-administration assessments are completed quarterly.
- Educate Resident Care Staff and Housekeeping to report any medications, OTC and CAM found in a residents' room who has not been assessed as able to safely self-administer medications or unlocked medications, OTC and CAM in the room of resident assessed as able to safely self-administer medications.

183b - Meds and Syringes Locked (continued)

- Residents' will be reminded of this regulation in the monthly resident council meeting beginning January 2026
- In-service scheduled on 12/30/2025 for wellness staff on self-medication protocols
- Incorporate assessment review results into quality SQIRT meetings beginning at January 15, 2026 meeting.

Responsible Party: Resident Wellness Director (or designee)

Time line: Audits beginning 12/18/2025

Licensee's Proposed Overall Completion Date: 01/08/2026

Implemented (████) - 04/13/2026)

183e - Storing Medications

26. 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 ██████████, Magic Mouthwash "Swish and spit 10ml every 6 hours as needed" prescribed to Resident ██████ was found in the home's medication cart with a discard date of ██████████

On ██████████, ██████████ tabs " Take every 4 hours as needed" prescribed to Resident ██████ were found in the home's medication cart with a discard date of ██████████

On ██████████ ██████████ " Take every 3 hours as needed" prescribed to Resident ██████, was found in the home's medication cart with a discard date of ██████████

Plan of Correction

Accept (████) 01/05/2026)

183e

Short Term Actions

Audit and Secure Medication Storage

Action Plan: Ensure all medications are stored properly and securely to comply with regulation 2600.183.e.

Steps:

- Conduct an audit of all medication storage areas to check for other expired, damaged or improperly stored medications.
- Damaged blister packs or packaging discovered during the audit have been sent back to the pharmacy and replacement blister packs in place.
- Secure all medications in accordance with the manufacturer's instructions, ensuring proper organization and conditions.

Responsible Party: Resident Wellness Director or Designee

Time line: Completed 11/20/2025

Staff Training on Medication Storage

Action Plan: Educate staff on proper medication storage techniques to prevent future violations.

Steps:

- Conduct a training session for all staff involved in medication management on appropriate storage conditions for

183e Storing Medications (continued)

medications.

- Review with staff the 2600.183.e regulations on medication storage.
- Document attendance of training session.

Responsible Party: Wellness and Operations Specialist or Designee

Time line: Completed 12/2/2025

Long Term Actions

Implement Storage Audits

Action Plan: Regularly monitor medication storage practices to ensure ongoing compliance with 2600.183.e.

Steps: • Establish a weekly schedule for comprehensive audits of medication storage. Audit med carts and storage areas weekly for 90 days.

- Compile a report of each audit for review by administration.

Responsible Party: Resident Wellness Director

Time line: Weekly for 90 days beginning 12/2/2025

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

Implemented (█) - 04/13/2026)

184a - Resident's Meds Labeled

27. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for Resident █ " 1 spray in each nostril once daily for 21 days" does not include a change in direction label with updated administration directions " Instill 2 sprays in each nostril once for 7 days".

Plan of Correction

Accept █ - 01/05/2026)

184a

Short Term Actions

Correct Medication Labeling

Action Plan: Ensure correct labeling of resident █'s medication to comply with regulations.

Steps:

- Immediately contact the pharmacy to rectify the missing information on resident █'s medication label.
- New corrected label with correct dosage and administration instructions was provided by the pharmacy.
- Complete audit of medication carts for accuracy in labeling.

Responsible Party: Resident Wellness Director or Designee

Time line: Completed 11/24/2025

Conduct Staff Training on Medication Labeling Requirements

Action Plan: Educate staff about medication labeling requirements to prevent future occurrences.

Steps:

- Mandatory training session for all staff involved in medication handling. Completed 12/2/2025
- Review the requirements of 2600.184.a

Responsible Party: Resident Wellness Director

184a - Resident's Meds Labeled (continued)

Time line: Completed 12/2/2025

Long Term Actions

Action Plan: Ensure all prescription labels match physician orders. .

Steps:

- Second training for med techs on December 30, 2025
- Cart audits completed to ensure prescription labels match physician orders for all medications
- Weekly cart audits for new prescriptions to ensure prescription labels match physicians orders for 90 days

Responsible Party: Resident Wellness Director or Designee

Time line: Weekly for 90 days beginning 12/2/2025

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

Implemented [redacted] - 04/13/2026)

185a - Implement Storage Procedures

28. Requirements

2600.

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

Description of Violation

On [redacted] at 8:31am, the glucometer for Resident [redacted] reads [redacted], this reading was documented in the resident's medication administration record as [redacted].

On [redacted] [redacted] for Resident [redacted] was found completely sealed in an opaque bag. The medication was delivered on [redacted]. The home's-controlled substance policy states that controlled medications are counted by two people when received. Staff person A confirmed medication was not counted by two people before being placed in the medication cart on the date it was delivered.

Repeat Violation [redacted]

Plan of Correction

Accept ([redacted] 01/05/2026)

185a

Immediate Actions:

Action Plan Re-educate CMT's on safe medication administration and documentation procedures.

Steps:

- Resident #11 glucose check was corrected
- In-Service completed with all CMT's staff involved in medication administration compliance of regulation 2600.185.a.

• Provide training on the importance of documenting narcotic counts before administration.

• Ensure understanding of the procedure requiring two authorized staff for reconciliation of narcotic counts.

Responsible Party: Wellness and Operations Specialist or Designee

185a Implement Storage Procedures (continued)

Timeline: Completed on 12/2/2025

Action Plan Reaffirm the controlled substance policy to ensure all medication staff remain in compliance.

Steps:

- Conduct a second policy review focusing on the controlled substances and medication administration.
- Second In service scheduled for December 30, 2025

Responsible Party: Resident Wellness Director or Designee

Timeline: Complete on or before 12/31/2025

Long Term Actions:

Action Plan Ensure ongoing compliance and proper documentation of medication counts.

Steps:

- Establish a weekly audit schedule for Narcotic Control and MARs for 90 days.
- Resident Wellness Director, LPN or designee will audit Glucometer records weekly for 90 days starting 12/2/2025
- Establish a weekly schedule for comprehensive audits of medication storage. Audit med carts and storage areas weekly for 90 days.
- Compile a report of each audit for review by administration.
- Review audit findings during monthly Quality Assurance (SQIRT) meetings beginning January 15th, 2026 to ensure ongoing compliance, for a period of six months,

Responsible Party: Resident Wellness Director or designee

Timeline: Weekly for 90 days beginning 12/2/2025

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

Implemented [REDACTED] 04/13/2026)

187a - Medication Record

29. Requirements

2600.

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

3. Name of medication.
5. Dosage form.
6. Dose.
7. Route of administration.
9. Administration times.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] " Inject subcutaneously with sliding scale four times daily. However, Resident [REDACTED] November 2025 medication administration record does not indicate name of medication, dosage form, dose, route of administration, administration times, special precautions, if applicable, diagnosis or purpose for the medication, including pro re nata (PRN), date and time of medication administration.

Resident [REDACTED] is prescribed [REDACTED] " Take one tablet by mouth once a daily. However, Resident [REDACTED] November 2025 medication administration record does not indicate, diagnosis or purpose for the medication,

187a - Medication Record (continued)

including pro re nata (PRN).

Resident [REDACTED] is prescribed [REDACTED] Instill 1 spray each nare daily as needed. However, Resident [REDACTED] November 2025 medication administration record does not indicate, diagnosis or purpose for the medication, including pro re nata (PRN).

Plan of Correction

Accept [REDACTED] - 01/05/2026)

187a

Comprehensive Review and Update of Medication Records

Action Plan: Ensure complete and accurate medication administration records for all residents.

Steps:

- *All physician orders printed and updated diagnoses added, Providers to sign and send to pharmacy to update MARs.*
- *Audit all current resident medication administration records for completeness and accuracy.*
- *Correct all identified deficiencies immediately.*
- *Develop a checklist for medication record accuracy verification.*

Responsible Party: Resident Wellness Director (or designee)

Time line: 11/24/2025

Immediate Staff Training on Medication Record Keeping

Action Plan: To improve staff understanding and execution of complete medication record keeping.

Steps:

- *Conduct a training session for all med techs on proper medication record documentation procedures. Held 12/2/2025*
- *Emphasize the importance of complete records, including all required details such as medication name, dosage form, dose, route, administration times special precautions, diagnosis or purpose and date and time of medication administration.*
- *Review/Training of Resident Wellness Director conducted on 12/18/2025 by Wellness & Operations Specialist including resident assessment requirements related to medication self-administration.*
- *Second wellness meeting scheduled for 12/30/25 to re-enforce with med techs accurate medication administration records for all residents.*

Responsible Party: Wellness & Operations Specialist (or designee)

Time line: Completed 12/18/2025

Long Term Actions

Regular Medication Record Audits

Action Plan: Sustain accuracy and completeness of medication records through ongoing monitoring.

Steps:

- *Monthly audits to be completed by Resident Wellness Director/ LPN Supervisor starting 12/18/2025 for 90 days to ensure compliance.*
- *Review of medication records in the facility's monthly Quality Assurance process (SQIRT meetings) beginning on January 15th, 2026.*
- *Document findings and address discrepancies promptly to prevent recurrence.*

Responsible Party: Resident Wellness Director (or designee)

Time line: Monthly for 90 days beginning 12/18/2025

187a - Medication Record (continued)

Licensee's Proposed Overall Completion Date: 12/23/2025

Implemented [REDACTED] - 04/13/2026)

187b - Date/Time of Medication Admin.

30. 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

Resident [REDACTED] is prescribed [REDACTED] " Give one tablet by mouth twice daily". Resident [REDACTED] November 2025 medication administration record does not include the initials of the staff person who administered [REDACTED] on [REDACTED] at 8:00am.

Plan of Correction

Accept [REDACTED] - 01/05/2026)

187b

Immediate Documentation Correction

Action Plan: To ensure accurate recording of medication administration for Resident [REDACTED]

Steps:

- Identify the staff member who administered the medication to Resident [REDACTED] on 11/18/2025 at 8:00 am.
- Record the initials of the respective staff member in the medication administration record.
- Ensure that the medication administration record is reviewed for any other missing entries.

Responsible Party: Resident Wellness Director (or designee)

Time line: 11/24/2025

Comprehensive Review and Update of Medication Records

Action Plan: Ensure complete and accurate medication administration records for all residents.

Steps:

- All physician orders printed and updated diagnoses added, Providers to sign and send to pharmacy to update MARs.
- Audit all current resident medication administration records for completeness and accuracy.
- Correct all identified deficiencies immediately.

Responsible Party: Resident Wellness Director(or designee)

Time line: 11/24/2025

Immediate Staff Training on Medication Record Keeping

Action Plan: To improve staff understanding and execution of complete medication record keeping.

Steps:

- Conduct a training session for all med techs on proper medication record documentation procedures. Held 12/2/2025
- Emphasize the importance of complete records, including all required details such as medication name, dosage form, dose, route, special precautions, diagnosis or purpose and date and time of medication administration.and administration times. Educate the team to check the dashboard to verify all medications have been signed off.
- Review/Training of Resident Wellness Director conducted on 12/18/2025 by Wellness & Operations Specialist including resident assessment requirements related to medication self-administration.

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

- Second wellness meeting scheduled for 12/30/25 to re-enforce with med techs accurate medication administration records for all residents.

Responsible Party: Wellness & Operations Specialist (or designee)

Time line: Completed 12/18/2025

Long Term Actions

Regular Medication Record Audits

Action Plan: Sustain accuracy and completeness of medication records through ongoing monitoring.

Steps:

- Weekly audits to be completed by Resident Wellness Director/ LPN Supervisor for 90 days to ensure compliance.
- Review of medication records in the facility's monthly Quality Assurance process (SQIRT meetings) beginning on January 15, 2026.
- Document findings and address discrepancies promptly to prevent recurrence.

Responsible Party: Resident Wellness Director (or designee)

Time line: Weekly for 90 days beginning 12/18/2025

Licensee's Proposed Overall Completion Date: 12/23/2025

Implemented [redacted] - 04/13/2026)

187d - Follow Prescriber's Orders

31. Requirements

2600.

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

Description of Violation

Resident [redacted] is prescribed [redacted] " Instill 2 sprays in each nostril once daily for 7 days". However, Resident [redacted] was administered [redacted] twice a day from [redacted].

Resident [redacted] is prescribed [redacted] " Inject subcutaneously four times daily before meals and at bedtime per sliding scale, 70-150=0 units, 151-200=2units, 201-250=4units, 251-300=6units, 301-350=8units, 351-400=10units and greater than 400 contact MD. On [redacted] at 8:30am the resident's blood glucose reading was recorded as [redacted] and [redacted] were administered. However, staff person D revealed during an interview that 2 units were administered to the resident and not documented on the medication administration record.

Plan of Correction

Accept [redacted] - 01/05/2026)

187d

Immediate Documentation Correction

Action Plan: To ensure accurate recording of medication administration for Resident [redacted]

Steps:

- Identify the staff member who administered the medication to Resident [redacted] on 11/18/2025 at 8:00 am.
- Record the initials of the respective staff member in the medication administration record.
- Ensure that the medication administration record is reviewed for any other missing entries.

187d - Follow Prescriber's Orders (continued)

Responsible Party: Resident Wellness Director (or designee)

Time line: 11/24/2025

Comprehensive Review and Update of Medication Records

Action Plan: Ensure complete and accurate medication administration records for all residents.

Steps:

- All physician orders printed and updated diagnoses added, Providers to sign and send to pharmacy to update MARs.
- Audit all current resident medication administration records for completeness and accuracy.
- Correct all identified deficiencies immediately.

Responsible Party: Resident Wellness Director(or designee)

Time line: 11/24/2025

Immediate Staff Training on Medication Record Keeping

Action Plan: To improve staff understanding and execution of complete medication record keeping.

Steps:

- Conduct a training session for all med techs on proper medication record documentation procedures. Held 12/2/2025
- Emphasize the importance of complete records, including all required details such as medication name, dosage form, dose, route, special precautions, diagnosis or purpose and date and time of medication administration.and administration times.

• Second wellness meeting scheduled for 12/30/25 to re-enforce with med techs accurate medication administration records for all residents.

• Daily audits for missed medications to be done by Resident Wellness Director/LPN supervisor for 30 days beginning 12/18/2025.

Responsible Party: Wellness & Operations Specialist (or designee)

Time line: 12/18/2025

Long Term Actions

Regular Medication Record Audits

Action Plan: Sustain accuracy and completeness of medication records through ongoing monitoring.

Steps:

- Weekly audits to be completed by Resident Wellness Director/ LPN Supervisor for 90 days to ensure compliance beginning 12/18/2025.
- Review of medication records in the facility's monthly Quality Assurance process (SQIRT meetings) beginning on January 15, 2026.
- Document findings and address discrepancies promptly to prevent recurrence.

Responsible Party: Resident Wellness Director (or designee)

Time line: Weekly for 90 days beginning 12/18/2025

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

Implemented [redacted] - 04/13/2026)

225c - Additional Assessment

32. Requirements

2600.

225c - Additional Assessment (continued)

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

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

Description of Violation

Resident [redacted] most recent assessment was completed on [redacted]

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

Plan of Correction

Accept [redacted] - 01/05/2026)

225c

Immediate Actions:

Action Plan 1: Ensure Resident [redacted] and Resident [redacted] needs are accurately assessed and documented in RASP.

Steps:

- Conduct a comprehensive re-assessment of Resident [redacted] and [redacted] to ascertain all current needs.
- Document all findings in the RASP, emphasizing how each need will be met.
- Communicate the updated assessment and plan to all relevant direct care staff to ensure understanding and compliance.

Responsible Party: Resident Wellness Director or Designee

Timeline: Completed 12/18/2025

Action Plan 2: Re-educate Resident Wellness Director on the importance of timely assessments for changes in resident condition.

Steps:

- Training of Resident Wellness Director on 12/18/2025 by Operations Specialist
- Organize a training session on recognizing significant changes in resident conditions and the importance of updating assessments promptly.
- Chart audit completed on 12/18/2025
- Emphasize documentation standards and accuracy to ensure care plans reflect current residents' needs.

Responsible Party: Wellness & Operations Specialist or Designee

Timeline: Completed on 12/18/25

Action Plan 3: Ensure current assessments for all residents are up-to-date and accurately reflect residents' needs.

Steps:

- Conduct an audit of all current resident RASPs to ensure compliance with regulation 2600.225c. on 12/18/2025
- Identify any gaps in assessments and initiate immediate updates where necessary.
- Prioritize the assessments of residents exhibiting significant changes in conditions.
- Audit will be reviewed in the monthly Quality Assurance (SQIRT) meeting, for a period of six months, beginning with

January review in the 1/15/26 meeting.

Responsible Party: Resident Wellness Director or Designee

Timeline: Monthly for 6 months beginning 12/18/2025

225c - Additional Assessment (continued)

Licensee's Proposed Overall Completion Date: 12/23/2025

Implemented [redacted] - 04/13/2026)

227d - Support Plan Medical/Dental

33. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for Resident [redacted] dated [redacted] indicates the resident has a need for assistance with repositioning, turning and transfers. The resident's support plan, dated [redacted] does not document how this need will be met.

The assessment for Resident [redacted], dated [redacted], indicates the resident has a need for a wheelchair. The residents support plan dated [redacted] does not document how this need will be met.

Repeat Violation [redacted]

Plan of Correction

Accept [redacted] 01/05/2026)

227d

Immediate Actions:

Action Plan 1: Ensure Resident [redacted] and Resident [redacted] support plans accurately document how medical and assistance needs are addressed.

Steps:

- Review and update Resident [redacted] support plan to include specific methods for repositioning, turning, and transfers.
- Review and update Resident [redacted] support plan to include the provision of a wheelchair and related support services.
- Communicate updates to all relevant staff to ensure consistent execution.
- Chart audit completed on 12/18/2025

Responsible Party: Resident Wellness Director or Designee

Timeline: Completed 12/18/2025

Action Plan 2: Ensure compliance with documentation requirements for all residents.

Steps:

- Assessments to be audited monthly by Resident Wellness Director/ LPN Supervisor to verify accuracy for 90 days.
- Communicate updates to all relevant staff to ensure consistent execution.
- Assessments will be updated by Resident Wellness Director within 5 days of any significant change.
- Chart audits of RASP to be completed monthly by Resident Wellness Director or LPN Supervisor for six months
- Chart audit results will be reviewed during monthly Quality Assurance (SQIRT) meetings, for a period of six months, beginning with review on January 1/15/2026.

Responsible Party: Resident Wellness Director or Designee

Timeline: Monthly for 6 months beginning 1/15/26

227d - Support Plan Medical/Dental (continued)

Licensee's Proposed Overall Completion Date: 12/22/2025

Implemented () 04/13/2026

236 - Staff Training

34. 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 A, who works in the Secure Dementia Care Unit (SDCU) had only 1.63 hours of training in dementia care during the January 2024 to December 2024 training year.

Direct care staff person B, who works in the Secure Dementia Care Unit (SDCU) had only 1.28 hours of training in dementia care during the January 2024 to December 2024 training year.

Plan of Correction

Accept () - 01/05/2026

236

Immediate Actions:

Action Plan Ensure immediate compliance with the mandatory training requirements for Direct Care Staff Person A and B.

Steps:

- Review current training records for Staff Person A and B.
- Schedule and provide training session for Staff Person A and B.
- Ensure Staff Person A and B completes the required 6 hours of training for the 2025 calendar year.
- Document completion of training in Staff Person A and B's personnel file and update training records accordingly.

Responsible Party: Administrative Services Director or Designee

Timeline: 12/31/2025

Long Term Actions:

Action Plan Implement an Annual Training Schedule.

Steps:

- Develop an annual training calendar that includes all mandatory training sessions.
- Communicate the schedule to all SDCU staff and management.
- Track compliance through hard copy training log.

Responsible Party: Administrative Services Director or Designee

Timeline: Completed 1/15/2026

Action Plan Conduct Audit and Review of Staff Training Compliance.

Steps:

- Conduct monthly audit of all employee files to review training status of all Direct Care Staff.
- Identify any staff that are out of compliance and ensure completion of required training(s).
- Ensure certificate or documentation of completion is on file.
- New Team members will complete mandatory training as part of their general Orientation/On-boarding process.
- Audits will be reviewed in Quality Assurance meetings (SQIRT) monthly, for a period of six months, beginning with the January 15, 2026 meeting.

Responsible Party: Administrative Services Director or Designee

Timeline: Monthly beginning 1/15/2026 for 6 months

236 - Staff Training (continued)

Licensee's Proposed Overall Completion Date: 12/22/2025

Implemented () - 04/13/2026)

251c - Standardized Forms

35. Requirements

2600.

251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident ()'s documentation of medical evaluation, dated (), was not completed on the Department's current standardized form.

Plan of Correction

Accept () - 01/12/2026)

251c

Immediate Form Update

Action Plan: Ensure all resident records are on the most recent Department-approved forms.

Steps:

- Immediately audit the admission paperwork for the resident records that moved in post 7/1/25 due to updated department-approved form to identify any instances where outdated forms have been utilized.
- Replace outdated forms with the Department-approved forms as of the current date.
- Resident #15's record is updated to reflect the information on the correct form.

Responsible Party: Resident Wellness Director or Designee

Time line: 11/30/25

Staff Training on Compliance

Action Plan: Educate the Community Relations Director and Administrative Services Director on the importance of using only Department-approved forms.

Steps:

- Conduct a training session for Community Relations Director and Administrative Services Director on recognizing approved forms and ensuring that all outdated documents are no longer utilized.

Responsible Party: Executive Operations Officer or Designee

Time line: 11/19/25

Monthly Compliance Sustainability Audit

Action Plan: Ensure all resident records are on the most recent Department-approved forms.

Steps:

- Complete a monthly audit for 3 months for residents starting on 11/24/25 to ensure any DME's for new admissions, significant changes or annuals are on Department's current standardized form.
- Record monthly audit and document any changes that were deemed necessary to ensure compliance with department approved forms.

Responsible Party: Community Relations Director or Designee

Time line: Monthly for 3 months beginning 11/24/25

Licensee's Proposed Overall Completion Date: 01/10/2026

Implemented () - 04/13/2026)