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

February 18, 2026

[redacted]
SH OPCO THE QUADRANGLE LLC
[redacted]
ATTN LICENSING
[redacted]

RE: QUADRANGLE PERSONAL CARE
3300 DARBY ROAD
HAVERFORD, PA, 19041
LICENSE/COC#: 14676

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/20/2025, 11/21/2025 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: *QUADRANGLE PERSONAL CARE* **License #**: *14676* **License Expiration**: *10/16/2026*

Address: *3300 DARBY ROAD, HAVERFORD, PA 19041*

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

Administrator

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

Legal Entity

Name: *SH OPCO THE QUADRANGLE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *12/17/1997* **Issued By**: *COPA*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *134* **Waking Staff**: *101*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *11/21/2025*

Inspection Dates and Department Representative

11/20/2025 On Site: [redacted]

11/21/2025 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *143* **Residents Served**: *101*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *25* **Residents Served**: *22*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *101*

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

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

11/20/2025 - Partial

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *01/23/2026*

Inspections / Reviews *(continued)*

01/27/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/16/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *01/30/2026*

01/29/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/16/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/16/2026*

02/18/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/16/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

23a - Activities of Daily Living Assistance

1. Requirements

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

Description of Violation

The assessment and support plan, dated [redacted], for resident [redacted] indicates the resident requires assistance with dressing. On [redacted], at approximately 10:30am the resident was observed by the agent of the department in the secured dementia care unit dining room in a hospital gown. The resident did not receive the required assistance.

Plan of Correction ***Accept ([redacted] 01/29/2026)***

Resident [redacted] was taken to [redacted] room and dressed. Care Managers completed rounds to ensure other residents were dressed appropriately.
Direct care staff will receive retraining on providing ADL assistance as identified in the resident support plan. 2. Lead Care Manager or the nurse on duty in Reminiscence will conduct daily rounds during the morning shift to verify residents are dressed appropriately according to the ISP.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur. Update: 1/27/26 Training will be completed by 2/16/26. Rounds will be formally documented by 2/16/26

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] - 02/17/2026)

25b - Contract Signatures

2. Requirements

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

Description of Violation

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

Plan of Correction ***Accept [redacted] - 01/29/2026)***

Executive Director signed the contract for resident [redacted] The Director of Sales or designee will audit current resident contracts to ensure all contracts are properly signed by all required parties. Any unsigned contracts will be signed within 5 business days of discovery. DOS/designee will conduct random audit for new resident contracts x3 months and reviewed in QAPI. Update: Audits were completed on 1/24/26
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] - 02/18/2026)

42b - Abuse

3. Requirements

42b - Abuse *(continued)*

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

Description of Violation

On [redacted] at approximately 7:40pm, in the home's secured dementia care unit (SDCU), resident [redacted] entered resident [redacted] bedroom uninvited. At this time, staff in the home were present in the common area with other residents watching television and coloring and did not notice when resident [redacted] left the common area. Staff stated that they heard resident [redacted] and resident [redacted] yelling at each other and resident [redacted] yelling "get out of my room I don't want you here." Staff person A ran towards both residents and observed resident [redacted] closing [redacted] bedroom door and resident [redacted] walking towards the common area saying, "that crazy person bit me". Staff assisted resident [redacted] back to the common area and called the nursing staff for the resident to be assessed. Resident [redacted]s right hand was observed red and bleeding. Resident [redacted]s most recent assessment dated [redacted], indicates the resident requires extensive supervision. Resident [redacted]s assessment indicates that the resident does not have any behavioral needs. Resident [redacted] most assessment dated [redacted] indicates the resident requires 24-hour direct supervision. An assessment was not completed for [redacted] or [redacted].

On [redacted], at approximately 9:30pm, in the home's SDCU, resident [redacted] entered resident [redacted]s bedroom uninvited. Staff person A was approached by resident [redacted] while in the common area who reported a "crazy [redacted] bit me." and showed staff A [redacted] bleeding right hand. Staff person A asked the resident to show [redacted] who bit them, and the resident directed them to resident [redacted]s room. Resident [redacted]s walker was in resident [redacted]s bedroom. Nursing staff was called to assess the resident and provide treatment. Staff disclosed that resident [redacted] does not like when people are in [redacted] bedroom. Resident [redacted]s progress note dated [redacted] states that the resident has a skin wound on the right hand with bruises and scratches. Resident [redacted]s most recent assessment dated [redacted] indicates the resident requires 24-hour direct supervision and indicates the resident has a behavioral need for agitation and aggression. However, the assessment does not document on how the need will be met, frequency or the responsible party. Resident [redacted]s most recent assessment dated [redacted], resident [redacted]s most recent assessment dated [redacted] and resident [redacted]s most recent assessment dated [redacted] indicate these residents require 24-hour direct supervision. On [redacted], two staff members were present in the SDCU from 3pm-11pm and one staff person from 9am-9pm.

In November 2025 on an unknown date, Resident [redacted] disclosed that staff person B utilized a "sit to stand" device to lift resident [redacted] out of bed and left the resident's room to take a phone call while leaving the resident unattended in the device for approximately 5 minutes. Resident [redacted] stated that [redacted] did not feel secure in the sit-to-stand device. The resident reported that [redacted] never previously used the device. The resident's most recent assessment and support plan, dated [redacted], states that the resident uses a wheelchair and walker for mobility and transfer and does not mention the use of a sit-to-stand device. Resident [redacted]s assessment states that [redacted] is at risk of a potential fall due to my limited mobility and requires one person to assist with mobility and transfer needs.

Plan of Correction ***Accept ([redacted] - 01/27/2026)***

Residents [redacted] and [redacted] were reviewed and updated. Residents in the SDCU will be reassessed by the IDT for behavioral needs and support plans updated to include specific interventions for identified behavioral needs. The staffing hours will be monitored by the Resident Care Coordinator monthly to ensure the proper staffing levels are maintained. Staffing audits will be reviewed x3 months.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

42b - Abuse *(continued)*

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] - 02/18/2026)

57c - 2 Hours/Day

4. 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], there were 98 residents in the home, including 26 residents with mobility needs, requiring a total minimum of 124 hours of direct care service. On this date, only 121.5 hours of direct care staffing was provided.

Plan of Correction ***Accept [redacted] - 01/27/2026)***

RCC reviewed current 2 week direct care hours to confirm that direct care hours are in place. The RCC will review the schedule 2 weeks in advance to ensure adequate direct care hours are available. Direct care hours will be reviewed in stand up. Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] - 02/18/2026)

57d - Waking Hours

5. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On [redacted], a total of 92.25 hours of direct care was required. However, only 91 of the required hours were provided during waking hours.

On [redacted], a total of 94.5 hours of direct care was required. However, only 93 of the required hours were provided during waking hours.

Plan of Correction ***Accept [redacted] - 01/27/2026)***

The RCC/Designee will verify that waking hours requirements are met before finalizing the weekly schedule. DLH will be reviewed in stand up. This will be reviewed x3 months and findings will be reviewed in QAPI.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] - 02/18/2026)

62 Contact List

6. Requirements

2600.
62. List of Staff Persons The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person C, the administrator, does not maintain an updated staff list. The first staff list provided was incorrect, then the home provided another staff list that had a staff person who was terminated on the list and a maintenance staff person not on the list.

Plan of Correction ***Accept (- 01/27/2026)***

HRM updated the current staff list. HR will update the list immediately upon any new hire or termination. HR will review the team member list monthly x3 months. Findings will be reviewed in QAPI.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented - 02/18/2026)

63a First Aid/CPR Training

7. 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 11pm-7am, 100 residents were present in the home. During this time 1 staff person was present in the home who was certified in CPR-first aid.

On [redacted], from 11pm-7am, 98 residents were present in the home. During this time 0 staff persons were present in the home who were certified in CPR-first aid.

On [redacted], from 3:15pm-11:00pm, 100 residents were present in the home. During this time 0 staff persons were present in the home who were certified in CPR-first aid.

Plan of Correction ***Accept 01/27/2026)***

Two-week schedule reviewed by RCC/Designee to confirm that CPR trained team members are on each shift per regulation. CPR training was held on 12/19/25. A CPR class is scheduled for 1/27/26. The schedule audit will ensure there is one CPR certified team member to 50 residents on each shift. The schedule will be reviewed weekly x3 months and reviewed at QAPI.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented - 02/18/2026)

65f Training Topics

8. Requirements

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

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

Description of Violation

Direct care staff person D did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2024.

Direct care staff person E did not receive training in medication self-administration training and instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2024.

Direct care staff person F did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2024.

Direct care staff person G did not receive training in medication self-administration training and instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2024.

Repeat Violation Date: [redacted] *et. al,* [redacted]

Plan of Correction ***Accept*** [redacted] ***- 01/27/2026)***

Team members D, E, F and G received mandatory training. A comprehensive annual training calendar has been developed for 2026 that schedules required training topics throughout the year. HR tracks the training for completion. Staff that do not complete the training will receive a written notification and will be required to make up the training within 30 days or be taken off the schedule. HR will complete random monthly audits x3 months. Findings will be reviewed in QAPI.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] ***- 02/18/2026)***

65g Annual Training Content

9. Requirements

2600.

65g Annual Training Content *(continued)*

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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person G did not receive training in The Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102) and 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 2024.

Repeat Violation Date: [redacted] *et. al*

Plan of Correction ***Accept*** [redacted] ***- 01/27/2026)***

Staff member G completed on 11/17/25 for OAPSA, and fire safety training 6/28/25. A comprehensive annual training calendar has been developed for 2026 that schedules required training topics throughout the year. Staff that do not complete the required training will receive a written notification and will be required to make up the training within 30 days or be taken off the schedule. HR will conduct random monthly audits x3 months and results will be reviewed in QAPI.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] ***- 02/18/2026)***

141b1 - Annual Medical Evaluation

10. Requirements

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

Description of Violation

Resident [redacted] *s most recent medical evaluation was completed on* [redacted]*. The resident's previous medical evaluation was not completed for 2024.*

Resident [redacted] *s most recent medical evaluation was completed on* [redacted]*. The resident's previous medical evaluation was completed on* [redacted] *Resident* [redacted] *s annual medical evaluation was not completed for 2025.*

Plan of Correction ***Accept*** [redacted] ***01/27/2026)***

A complete audit of all resident files was completed 12/23/25. See attached documentation. Resident DME's are up to date. The Resident Care Director/Wellness nurse will track the DME due dates through the EMR. The Administrator is completing weekly random audits of resident charts through the second quarter effective 1/5/26. Findings will be reviewed in QAPI.

141b1 - Annual Medical Evaluation (continued)

Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented (- 02/18/2026)

183d - Prescription Current

11. Requirements

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

Description of Violation

On , at 3:10pm resident s tablet, was in the home's the medication cart in memory care; however, the medication was discontinued on .

Repeat Violation Date: et. al

Plan of Correction ***Accept 01/27/2026)***

The discontinued medication was immediately removed from the medication cart and properly disposed. Medication carts were audited to ensure there were no other discontinued medications in the cart. Weekly medication cart audits will be conducted by the LPN/Medication technicians and reviewed by the RCD/Designee x3 months and reviewed at QAPI. Nursing staff will receive training on the discontinued medication removal procedure.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented (- 02/18/2026)

184a - Resident's Meds Labeled

12. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for resident USB does not include instructions for administration.

Repeat Violation Date: et. al

Plan of Correction ***Accept (- 01/27/2026)***

Appropriate label was added to the medication. Med cart was audited to confirm all medications had proper labels.

184a - Resident's Meds Labeled (continued)

Training for LPNS/med techs on proper labeling will be conducted.
Weekly medication cart audits will be conducted to confirm medications are properly labeled. Audits reviewed in QAPI
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] - 02/18/2026)

185a - Implement Storage Procedures

13. 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 [redacted]. On [redacted], the accountability record was not signed when one pill was removed to administer at 2:00pm.

Resident [redacted] is prescribed [redacted]. On [redacted], the accountability record was not signed when one pill was removed to administer at 8:00am.

The home's-controlled substance policy states that when controlled medication is administered, the licensing nurse administering the medication immediately enters the following information on the accountability record when removing dose from the controlled storage: Date and time of administration, amount administered and signature of the nurse administering the dose.

Plan of Correction ***Accept ([redacted] 01/27/2026)***

Nursing staff will receive a retraining on controlled substance accountability procedures by 2/15/26. The training will emphasize that accountability records must be signed immediately when the medication is administered.
RCD/designee will randomly audit narcotic reconciliation sheet weekly x3 months. Findings will be reported at QAPI.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] 02/18/2026)

187b - Date/Time of Medication Admin.

14. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

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

Description of Violation

Resident [redacted] is prescribed [redacted] take one tablet by mouth at bedtime. Resident [redacted]s November 2025 medication administration record does not include the initials of the staff person who administered [redacted], [redacted], and [redacted] at 9:00pm.

Resident [redacted] is prescribed [redacted] take one tablet by mouth every 12 hours. Resident [redacted]s November 2025 medication administration record does not include the initials of the staff person who administered [redacted], [redacted], and [redacted] at 9:00pm.

Plan of Correction ***Accept[redacted] 01/27/2026)***

Licensed nursing staff /med techs will receive retraining on medication administration documentation requirements including initialing at the time medication is administered. Monthly MAR audits will be conducted by the RCD/Med Tech on a random sample of resident records to verify complete and timely documentation x 3months and reviewed In QAPI.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented ([redacted] - 02/18/2026)

225c - Additional Assessment

15. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [redacted]s most recent assessment was completed on [redacted] indicates behaviors are not applicable. On [redacted], resident [redacted] was involved in an incident with another resident in which [redacted] was the [redacted]

Plan of Correction ***Accept[redacted] - 01/27/2026)***

Resident [redacted] ISP was updated to include behavior. The RCD/designee will review incident reports daily and determine if a reassessment is required. When reassessment is triggered, the wellness nurse will be notified to coordinate the reassessment with the RCC.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented ([redacted] - 02/18/2026)

227b - Support Plan Content

16. Requirements

2600.
227.b. A home may use its own support plan form if it includes the same information as the Department's support plan form.

Description of Violation

The home does not use the Department's support plan form. The home's support plan dated [redacted] for resident [redacted] does not include behavioral needs such as [redacted] and [redacted].

The home does use the Department's support plan form. The home's support plan dated [redacted] for resident [redacted] indicates the resident has a behavioral need for agitation and aggression. However, the assessment does not document on how the need will be met, frequency or the responsible party.

The home does not use the Department's support plan form. The home's support plan dated [redacted] for resident [redacted] does not include behavioral needs such as [redacted] and [redacted].

Plan of Correction ***Accept [redacted] - 01/27/2026)***

The nurses will be provided training on how to customize resident support plans to address behaviors such as aggression, irritability, and hallucinations.
Resident [redacted] support plan has been updated to reflect the interventions put in place to meet resident's needs.
Random monthly audits of support plans will be completed by the RCC/designee x3 months. Findings will be reviewed at QAPI. Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] - 02/18/2026)

227g -Support Plan Signatures

17. Requirements

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

Description of Violation

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

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

227g -Support Plan Signatures (continued)

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

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

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

Repeat Violation Date: [redacted] et al

Plan of Correction ***Accept [redacted] - 01/27/2026)***

Resident[redacted] and [redacted]support plans were reviewed and signed by residents/Responsible party. Support plans were reviewed (see attached documentation). Support plans have been reviewed and signed as appropriate. The administrator is completing weekly random audits of resident files for completeness x3 months and finding reviewed during QAPI.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] - 02/18/2026)

231c - Preadmission Screening

18. Requirements

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

Description of Violation

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

Repeat Violation Date: [redacted], et al

Plan of Correction ***Accept [redacted] - 01/27/2026)***

Resident [redacted] has had an updated cognitive pre-screen completed Resident files were audited by 12/23/25. Files that had missing cognitive pre-screens or dates were incorrect were updated. (see attached documentation). The sales director is responsible to ensure mandatory documents are received and are correct prior to the date of move in. Random audits will be completed by the ED/Designee x3 months and reviewed in QAPI.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

231c Preadmission Screening *(continued)*

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented (02/18/2026)

234b - Support Plan Needs Elements

19. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated , for resident does not identify the resident's behavioral needs. On , Resident was involved in a resident to resident altercation and was also the aggressor in the incident.

Plan of Correction ***Accept - 01/27/2026)***

Resident support plan was updated to reflect behavior needs. Residents in the SDCU will be reassessed by the IDT for behavioral needs and support plans updated to include specific interventions for identified behavioral needs. Support plans will specifically address behavioral needs including but not limited to agitation, aggression, anxiety, depression, and resistiveness to care. Residents exhibiting new behaviors will be discussed during weekly IDT meeting to include support plan update as needed.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented - 02/18/2026)

236 - Staff Training

20. 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 G, who works in the Secure Dementia Care Unit (SDCU) had only 5 hours of training in dementia care during the 2024 training year.

Repeat Violation Date: , et al,

Plan of Correction ***Accept 01/27/2026)***

Staff person G completed the required 6 hours of training. Team members that work in SDCU training will be audited by HR/Designee quarterly to ensure training compliance. Findings will be reviewed during QAPI meeting.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

236 Staff Training *(continued)*

Implemented [redacted] - 02/18/2026)

251c Standardized Forms

21. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident [redacted]s annual medical evaluation dated [redacted] was not completed on the Department's current standardized form for personal care home. It was completed on the Department's current standardized form for assisted living residence.

Resident [redacted]s change of status medical evaluation dated [redacted] was not completed on the Department's current standardized form for personal care home. It was completed on the Department's current standardized form for assisted living residence.

Plan of Correction ***Accept [redacted] - 01/27/2026)***

Resident [redacted] and [redacted] have had DME updated using the correct forms. Charts were audited to ensure the PC DME was used. facility has obtained and is currently using the correct DHS PC DME. A training on the new forms was held for wellness nurses on 12/4 and 12/10 . When completed forms are returned they are being reviewed by the RCD/Wellness nurse/Designee.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *02/16/2026*

Implemented [redacted] - 02/18/2026)