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

March 30, 2026

[redacted] REGIONAL CLINICAL VP
MCAP WILLOW GROVE OPERATOR LLC
[redacted]

RE: COMMONWEALTH SENIOR LIVING
AT WILLOW GROVE
1120 YORK ROAD
WILLOW GROVE, PA, 19090
LICENSE/COC#: 13994

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/25/2025, 11/26/2025, 12/01/2025 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: *COMMONWEALTH SENIOR LIVING AT WILLOW GROVE* **License #**: *13994* **License Expiration**: *10/08/2026*

Address: *1120 YORK ROAD, WILLOW GROVE, PA 19090*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *MCAP WILLOW GROVE OPERATOR LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *02/15/1990* **Issued By**: *Commonwealth of Pennsylvania, L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *118* **Waking Staff**: *89*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *12/01/2025*

Inspection Dates and Department Representative

11/25/2025 - On-Site: [redacted]
11/26/2025 - On-Site:
12/01/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *122* **Residents Served**: *74*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Sweet Memories* **Capacity**: *52* **Residents Served**: *27*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *74*

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

Have Mobility Need: *44* **Have Physical Disability**: *1*

Inspections / Reviews

11/25/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/05/2026*

Inspections / Reviews *(continued)*

01/06/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/17/2026*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/21/2026*

03/12/2026 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/17/2026*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/16/2026*

03/30/2026 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/17/2026*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 10/2825, at 10:45 PM, the local police were called by resident #1 who felt scared and threatened by staff member A who reportedly threatened to bring their thuggish people to hurt the resident. This allegation of abuse was not reported to the local area agency on aging.

Plan of Correction ***Accept (- 01/06/2026)***

The incident on 10/28/25 where Resident #1 felt threatened by Staff person A was investigated at time of report. Resident #1 made a statement at time of incident to the Executive Director that did not feel scared and threatened by Staff Person A and that had over-reacted to Staff Person A opening drawer to obtain the lotion that had requested Staff Person A to obtain for This incident has now been reported to the local Area Agency on Aging as of 1/5/2026.

The Executive Director and RCD have been trained as to this regulation and company policy(see attached training). Moving forward, the ED, RCD or Designee will report any suspected abuse to the local Area Agency on Aging in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons. Moving forward, incidents of suspected abuse will be reviewed with a member of the Regional Director Team to ensure compliance to regulatory standards. The ED or Designee will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented (- 03/11/2026)

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 10/28/25 at 10:45 PM, an altercation occurred between resident #1 and staff member A where resident #1 reported they had felt threatened and scared. The home did not develop and implement a plan of supervision or suspend staff member A.

Plan of Correction ***Accept (- 01/06/2026)***

The incident on 10/28/25 where Resident #1 felt threatened by Staff person A was investigated at time of report. Resident #1 made a statement at time of incident to the Executive Director that did not feel scared and threatened by Staff Person A and that had over-reacted to Staff Person A opening drawer to obtain the lotion that had requested Staff Person A to obtain for During the time of survey when Resident A indicated did feel scared and threatened by Staff Person A, to ensure compliance to regulatory standards, Staff Person A was placed on an Administrative Leave pending investigation outcome and termination of employment and remains on Leave from the community and job.

15b - Supervisor Plan (continued)

The Executive Director and RCD have been trained as to this regulation and company policy(see attached training). Moving forward, incidents of suspected abuse will be reviewed with a member of the Regional Director Team to ensure compliance to regulatory standards as it relates to a Supervisor Plan or Suspension of the staff member. The ED or Designee will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented (- 03/11/2026)

16c - Written Incident Report

3. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 10/28/25, at 10:45 PM, an altercation between resident #1 and staff member A occurred when the staff threatened and intimidated the resident. The home submitted the incident report to the Department on 10/30/25 at 8:30 AM.

Plan of Correction ***Accept (- 01/06/2026)***

The RCD, ED and Managers have been trained as to this regulatory standard and company policy (see attached training). Going forward, incidents will be reviewed as part of the Stand up Meeting and the ED, RCD or Designee will be responsible to complete the written incident report to ensure compliance to this regulation. The Manager on Duty and Medication Technicians will be responsible to report any incidents to the RCD or ED if they are not at the community for review and completion of a written incident report to the Department if applicable.

The ED will be responsible to report on the effectiveness of this plan monthly x 90 days then resume quarterly as part of Quality Management throughout 2026.

Licensee's Proposed Overall Completion Date: *01/04/2026*

Implemented (- 03/11/2026)

4. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 09/25/25, resident #2 had an unwitnessed fall in room. Resident #2 was sent to Hospital where the resident was diagnosed with The home did not submit an incident report to the Department.

Repeat Violation: 11/13/24 et. al.

16c - Written Incident Report *(continued)*

Plan of Correction ***Accept (- 01/06/2026)***

The family was made aware of the incident on 9/25/25 in which Resident #2 had an unwitnessed fall and was sent to Hospital and subsequently diagnosed with a , but it was not reported appropriately per regulatory requirements. Resident #2 no longer resides at the community.

The Executive Director and RCD have been trained as to this regulation and company policy(see attached training). Moving forward, the ED, RCD or Designee will report any incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Additionally, incidents and conditions will be reviewed as part of Stand-up meeting to ensure compliance to regulatory standards as it relates to reportable incidents and conditions. The ED or Designee will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented (- 03/11/2026)

17 - Record Confidentiality

5. 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 11/25/25, at 9:49 AM, a staff laptop displaying personal resident information was found open, unlocked, unattended, and accessible on the first floor medication cart (med cart).

Repeat Violation: 03/24/25 et. al.

Plan of Correction ***Accept (- 01/06/2026)***

The laptop that was left open displaying resident information and was unlocked, unattended and accessible was corrected at time of survey (laptop was closed, locked and inaccessible). Staff has been trained as to this regulation and company policy (see attached training). Going forward, the RCD or Designee will do random and regular audits to ensure compliance to regulatory standards as it relates to record confidentiality and laptops left unlocked, unattended and accessible with resident information visible.

The RCD/designee will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

Licensee's Proposed Overall Completion Date: *01/04/2026*

Implemented (- 03/11/2026)

25b - Contract Signatures

6. 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 #3 was not signed by the resident.

- The resident-home contract, dated [redacted] for resident #4 was not signed by the resident or a representative of the home.

- The resident-home contract, which is not dated, for resident #5 was not signed by the resident.

- The resident-home contract, dated [redacted] for resident #6 was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

Residents #4 and #6 no longer reside at the community. Signatures on contracts for resident #3, #5 will be obtained by 1/10/26. An audit of current resident contracts has been completed and any missing resident signatures will be obtained by 1/22 as it relates to this violation. ED/BOM were trained as to this regulation and company policy(see attached training). Going forward, the Executive Director, BOM or Designee will be responsible to ensure resident signatures are obtained on resident contracts to ensure compliance with the regulatory standard.

The BOM will be responsible to perform monthly audits as part of Quality Management and report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented ([redacted] - 03/11/2026)

25b SOPa - Rent Rebate: Contract

7. Requirements

2600.
25b.a. The resident-home contract is to include whether the home collects a portion of a resident's rent rebate under § 2600.25(d) (relating to resident-home contract).

Description of Violation

- The resident-home contract, dated [redacted] for Resident #1 does not indicate whether the home collects a portion of the resident's rent rebate benefit.

- The resident-home contract, dated [redacted] for Resident #4 does not indicate whether the home collects a portion of the resident's rent rebate benefit.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

Resident #4 no longer resides at the community. Signatures on the rent rebate in the resident contract for resident #1 will be obtained by 1/10/25. An audit of rent rebates in current resident contracts has been completed and any missing resident signatures will be obtained by 1/22 as it relates to this violation. ED/BOM were trained as to this regulation and company policy(see attached training). Going forward, the Executive Director, BOM or Designee will be responsible to ensure resident signatures are obtained on resident contracts to ensure compliance with the regulatory standard.

25b SOPa - Rent Rebate: Contract (continued)

The BOM will be responsible to perform monthly audits as part of Quality Management and report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented (- 03/11/2026)

28e - Death of a Resident

8. Requirements

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

- Resident #7 passed away on Resident #7's personal belongings were removed from their room on and a refund was processed on However, the home continued to charge for eldercare services, laundry and cable TV for the period between the resident's passing and when the resident's room had been cleared of all possessions making the refund amount incorrect. This error was discovered during this inspection.

- Resident #8 passed away on Resident #8's personal belongings were removed from their room on ; however, a refund for the amount of the difference between any payments made and the cost of eldercare provided to the resident prior to their passing was not issued until .

For residents under 60 years of age, the home may continue to charge until the room is cleared of the resident's personal property. For residents above 60 years of age, homes must follow the requirements of the Elder Care Payment Restitution Act, enacted on December 9, 2002. Following the death of a resident, the home will pay the personal representative or guardian of the resident the amount of the difference between any payment made and the cost of eldercare actually provided to the resident. This payment shall be made within 30 days from the date that the resident's bedroom is cleared of the resident's personal property. If the resident contract does not distinguish the costs of care from other costs such as room and board, then the Department will cite a violation unless the home refunds the total amount paid for food, shelter, and services for the period following the resident's death. No matter whether the Department cites a regulatory violation, the resident's personal representative or guardian may pursue the remedies available under the Elder Care Payment Restitution Act. See 35 P.S. § 10226.103(b). Personal Care Homes should also be aware that noncompliance with the Elder Care Payment Restitution Act could lead to criminal penalties. See 35 P.S. § 10226.107. Homes are encouraged to develop policies and practices that comply with the Elder Care Payment Restitution Act to address the conditions under which charges may continue to accrue after the death of the resident, as well as the provision of refunds. (Q/A January 2019-2600.28(e)).

28e - Death of a Resident *(continued)*

Plan of Correction ***Accept (- 01/06/2026)***

Laundry and cable TV for the period between the resident's passing and when the resident's room had been cleared of all possessions for Resident # 7 was discovered during this inspection. The error was corrected that same day and an additional refund check was issued 11/25/25 to the Responsible Party (see attached check). The BOM and Executive Director have been trained as to this regulation and company policy(see attached training). Moving forward, the BOM or Designee will be responsible to audit refunds for resident deaths to ensure compliance to regulatory standards.

The BOM will report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly. For 90 days, the Executive Director/designee will be responsible to perform monthly audits as part of Quality Management to ensure compliance with the regulatory standard throughout 2026.

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

Implemented (- 03/11/2026)

41e - Signed Statement

9. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

The records for residents #3 and #6 do not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept (- 01/06/2026)***

Resident #6 no longer resides at the community. A signed statement acknowledging receipt of resident rights and complaint procedures will be obtained for Resident #3 by 1/10/26. An audit of current resident contracts has been completed to identify any missing resident signatures on the signed statement acknowledging receipt of resident rights and complaint procedure. Any required resident signatures will be obtained by 1/22 as it relates to this violation. ED/BOM were trained as to this regulation and company policy(see attached training). Going forward, the Executive Director, BOM or Designee will be responsible to ensure resident signatures are obtained to ensure compliance with this regulatory standard.

The BOM will be responsible to perform monthly audits as part of Quality Management and report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly. For 90 days, the Executive Director/designee will be responsible to perform monthly audits as part of Quality Management to ensure compliance with the regulatory standard.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented (- 03/11/2026)

42b - Abuse

10. 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 10/28/25, at 10:45 PM, resident #1 and staff member A had an altercation at the home. Resident #1 had requested staff member A to assist resident in applying lidocaine cream to help with resident #1's arthritis. Staff member A mistakenly started looking for the cream in the resident's drawers which upset resident #1 causing the resident to yell at the staff member. The staff member responded by stating something along the lines of don't make me bring someone up here, in fact [redacted] is outside right now. Resident #1 understood this to mean that the staff member was going to bring someone in to hurt the resident. The resident called the police because the resident felt scared and threatened.

Repeat Violation: 03/24/25 et. al.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

The incident on 10/28/25 where Resident #1 felt threatened by Staff person A was investigated at time of report. Resident #1 made a statement at time of incident to the Executive Director that [redacted] did not feel scared and threatened by Staff Person A and that [redacted] had over-reacted to Staff Person A opening [redacted] drawer to obtain the lotion that [redacted] had requested Staff Person A to obtain for [redacted] ED/RCD, Management Team and Direct Care Staff have been trained as to Abuse as it relates to this regulation (see attached training). The ED, RCD or Designee will be responsible for additional training as to this regulatory standard monthly x90 days and then quarterly throughout 2026.

The ED or Designee will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

Licensee's Proposed Overall Completion Date: *01/31/2026*

Implemented ([redacted] - 03/11/2026)

42f - Mail Access

11. Requirements

2600.
42.f. A resident has the right to receive and send mail.
2. Incoming mail may not be opened or read by staff persons unless upon the request of the resident or the resident's designated person.

Description of Violation

On 12/01/25, at 11:58 AM, two large piles of undelivered mail were found behind the nurse's station in the memory care unit (Sweet Memories). These piles included insurance or medical bills/statements, greeting cards, a United States Census packet and a greeting card addressed to resident #10 with a post date of July 7, 2025.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

The mail for Resident #10 observed in the nurse's station of Sweet Memories was forwarded to the Responsible Party on record at time of survey. The 2 large additional piles of mail were forwarded to the Responsible Party on record on 12/26/25. The BOM, ED, Management Team, Concierge Staff and Med Techs have been trained as to the regulatory standards (see attached training). The Responsible Parties of residents in Sweet Memories will be notified by 1/10/26 to complete by 1/31/26 an official change of address with the USPS to ensure going forward, mail is sent through USPS to the Responsible Party on record to manage on behalf of the resident. The BOM will be

42f - Mail Access (continued)

responsible to forward any mail received for current residents of Sweet Memories to the Responsible Party on record until 1/31/26 and will report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly. For 90 days, the Executive Director/designee will be responsible to perform regular and random audits as part of Quality Management to ensure compliance with the regulatory standard.

Licensee's Proposed Overall Completion Date: *01/31/2026*

Implemented ([redacted] - 03/11/2026)

63a - First Aid/CPR Training

13. 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

During this inspection, the home's census is 74 residents indicating the home requires two staff trained in first aid and certified in obstructed airway techniques and CPR. On the dates and times listed below, only 1 staff member was present in the home meeting this requirement:

- *10/29/25 - on the 3:00 PM to 11:00 PM shift and the 11:00 PM to 7:00 AM shift,*
- *11/05/25 - on the 11:00 PM to 7:00 AM shift,*
- *11/23/25 - on the 3:00 PM to 11:00 PM shift and the 11:00 PM to 7:00 AM shift.*

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

CPR class was conducted on 12/23/25 to ensure compliance to this regulatory standard. Going forward, the RCD or Designee will be responsible to schedule additional classes thru Q1 2026 and ongoing.

The BOM or Designee will be responsible to perform monthly audits to ensure compliance to this regulatory standard as part of Quality Management monthly x 90 days then resume quarterly throughout 2026. Additionally, the Executive Director/Designee will be responsible to perform audits monthly x 90 days then resume quarterly to ensure compliance and evaluate effectiveness of this plan as part of Quality Management throughout 2026.

Licensee's Proposed Overall Completion Date: *01/31/2026*

Implemented ([redacted] - 03/11/2026)

65a - FS Orientation 1st Day

14. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

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

65a - FS Orientation 1st Day *(continued)*

7. Telephone use and notification of emergency services.

Description of Violation

The orientation materials for staff member A, whose first day of work was [redacted] do not indicate who provided orientation on the following topics to staff member A or if it was even completed:

- *evacuation procedures,*
- *staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable,*
- *the designated meeting place outside the building or within the fire-safe area in the event of an actual fire,*
- *smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable,*
- *the location and use of fire extinguishers,*
- *smoke detectors and fire alarms,*
- *telephone use and notification of emergency services.*

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

Staff Member A did receive Orientation as per this regulatory standard, but documentation was not obtained as required. Staff Member A continues to be out on [redacted] The BOM and ED have been trained to this regulatory standard and company policy (see attached training). An audit of all Staff Orientation will be conducted by 1/31 to identify any staff out of compliance and any missing required orientation completed. Going forward, the BOM will be responsible to audit all Orientation documentation to ensure new hires have received required Orientation and compliance to this regulatory standard.

The ED will be responsible to audit new hire Orientation beginning 1/1/26 x 60 days to ensure compliance to this regulatory standard. The ED will be responsible to report on the effectiveness of this plan monthly x 60 days then resume quarterly as part of Quality Management throughout 2026.

Licensee's Proposed Overall Completion Date: *01/31/2026*

Implemented ([redacted] - 03/11/2026)

65b - Rights/Abuse 40 Hours

15. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

The orientation materials for staff member A, who would have completed their 40th scheduled work hour in [redacted], do not indicate who provided orientation on the following topics to staff member A or if it was even completed:

- *resident rights,*
- *emergency medical plan,*
- *mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102),*
- *reporting of reportable incidents and conditions.*

65b - Rights/Abuse 40 Hours *(continued)*

Plan of Correction ***Accept (- 01/06/2026)***

Staff Member A did receive Orientation as per this regulatory standard, but documentation was not obtained as required. Staff Member A continues to be out . The BOM and ED have been trained to this regulatory standard and company policy (see attached training). An audit of current staff records will be conducted by 1/31 to identify any staff out of compliance as it relates to this regulatory standard and any missing required orientation will be completed. Going forward, the BOM will be responsible for auditing all Orientation documentation to ensure new hire compliance to this regulatory standard.

The ED will be responsible to audit new hire Orientation beginning 1/1/26 x 60 days to ensure compliance to this regulatory standard. The ED will be responsible to report on the effectiveness of this plan monthly x 60 days then resume quarterly as part of Quality Management throughout 2026.

Licensee's Proposed Overall Completion Date: *01/31/2026*

Implemented (- 03/11/2026)

65f - Training Topics

16. 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 personal care service needs of the resident and safe management techniques during the 2024 training year.

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

Repeat Violation: 11/13/24 et. al.

Plan of Correction ***Accept (- 01/06/2026)***

The BOM and ED have been trained to this regulatory standard and company policy (see attached training). Community will complete an audit by 1/31/2026 to assure staff have completed regulatory required training for 2025. Training will be completed as required and moving forward training requirements will be met. Going forward, the BOM will be responsible to monitor required annual training and report monthly as part of Quality Management throughout 2026 to ensure compliance to this regulation and effectiveness of the plan. ED will be responsible to audit annual Training Plans to ensure compliance to training topics as it relates to this regulatory

65f - Training Topics (continued)

standard (see attached 2026 Training Plan).

Licensee's Proposed Overall Completion Date: *01/31/2026*

Implemented ([redacted] - 03/11/2026)

65g - Annual Training Content

17. 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.
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 D 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, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during the 2024 training year.

- Staff person E did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights during the 2024 training year.

- Staff person F did not receive training in resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during the 2024 training year.

Repeat Violation: 11/13/24 et. al.

Plan of Correction ***Directed ([redacted] - 01/06/2026)***

The BOM and ED have been trained to this regulatory standard and company policy (see attached training). Community will complete an audit by 1/31/2026 to assure staff have completed regulatory required training for 2025. Training will be completed as required and moving forward training requirements will be met. Going forward, the BOM will be responsible to monitor required annual training and report monthly as part of Quality Management throughout 2026 to ensure compliance to this regulation and effectiveness of the plan. ED will be responsible to audit annual Training Plans to ensure compliance to training topics as it relates to this regulatory standard (see attached 2026 Training Plan).

Proposed Overall Completion Date: 01/31/2026

Directed Plan of Correction (slw 1/6/26):

1. In addition to the steps noted in the submitted plan of correction the ED will ensure staff D, E and F have completed the missing trainings within the next 15 days of receipt of this plan of correction.

2. Documentation of the trainings will be maintained for the Departments review.

65g - Annual Training Content (continued)

3. The BOD will review all staff trainings at least bi-annually to ensure all required trainings are completed by the end of 2026, starting immediately.

Directed Completion Date: *01/21/2026*

Implemented ([redacted] - 03/11/2026)

66b - Training Plan Content

18. Requirements

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

Description of Violation

The home's staff training plan does not include:

- *the name, position and duties of each direct care staff person,*
- *the required training courses for each staff person,*
- *the dates, times and locations of the scheduled training for each staff person for the upcoming year.*

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

The 2026 Staff Training Plan has been audited and updated to include required content in compliance with this regulatory standard (see attached updated 2026 Training Plan). The BOM and ED have been trained to this regulatory standard and company policy (see attached training). Going forward, the ED will responsible to develop annual training plans in compliance to this regulatory standard and will review any training plans developed quarterly as part of Quality Management throughout 2026.

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

Implemented ([redacted] - 03/11/2026)

81b - Resident Personal Equipment

19. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #5 has a bedside mobility device on each side of their bed, uncovered. These devices have several openings: on the top portion of each end the opening measures 8 inches wide by 5.5 inches high. This does not adhere to the FDA guidelines which states "If any openings within the device exceed 120 mm (4 3/4 inches), a cover that allows for safe gripping and use of the device for its intended purpose must be in place."

Repeat Violation: 11/13/24 et. al.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

The bed enabler for Resident #5 now has a cover in place(completed 12/4/25). The RCD, Managers and staff in Housekeeping, Maintenance, Direct Care have been trained as to this regulation and company policy (see attached

81b - Resident Personal Equipment (continued)

training). Going forward, the housekeeping staff and direct care staff will be responsible to report any bed mobility device not in compliance with regulatory standard. Additionally going forward, the Housekeeping staff will audit resident rooms during routine housekeeping to ensure compliance and the RCD or Designee will be responsible to perform regular random audits to ensure compliance to regulatory standard.

The RCD or Designee will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

85a - Sanitary Conditions

20. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

Resident #3 and #9 live in a shared room and share a bathroom. On 12/01/25 at 12:18 PM, two sets of unmarked towels were hanging on the same towel rack in the bathroom. There is no indication which set of towels belong to which resident.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

The towel racks belonging to resident #3 and #9 have been labeled to designate which towel belongs to each resident. Staff have been trained to the requirements of this regulation (see attached training). Going forward, Housekeeping staff will be responsible to ensure towel racks in resident rooms occupied by 2 residents are labeled to designate which towel belongs to each resident and will perform regular checks during weekly housekeeping of resident rooms to ensure compliance to this regulation.

The ED or Designee will be responsible to perform regular and random audits to ensure compliance to this regulation and report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/30/2026)

85d - Trash Receptacles

21. Requirements

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

Description of Violation

On 11/25/25 at 9:32 AM there was a partially full, uncovered, unattended trash can in the memory care kitchen.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

The Trash Receptacle in memory care was replaced at time of survey with a covered trash can. The Maintenance Director, RCD, ED, Program Director and staff in the housekeeping, direct care and dining departments have been

85d - Trash Receptacles (continued)

trained as to this regulation and company policy (see attached training). Going forward, housekeeping staff will be responsible to ensure compliance with regulatory standard.

The Maintenance Director will be responsible to perform regular and random audits to ensure the trash cans in kitchens and bathrooms are covered and to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

85e - Trash Outside Home

22. 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 11/25/25 at 9:36 AM several trash items were found outside of the home. By the dumpster, a mattress, a broken chair, a bathroom vanity and sink, a cabinet, several discarded pieces of wood and aluminum siding, and a table leg, were on the ground surrounding the dumpster area. Also, the dumpster side access door had been left open. By the recycle bin, two empty furniture boxes were found outside of the bin. Finally, two trash bins filled with trash were found outside by the rear of the home where the home accepts deliveries.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

Trash and furniture around the dumpster found at time of inspection was cleaned upon finding. The uncovered trash receptacles were removed. Direct Care, Ancillary staff, Directors and ED have been trained as to this regulatory standard and company policy (see attached). Going forward, a roll off dumpster that was obtained on 12/4/25 and on site, will be utilized to dispose of bulk items. A sign has been placed on the dumpster to remind staff to keep dumpster doors and lids closed and dumpster area free of trash (see attached photo). Going forward, staff will dispose of trash directly in the trash dumpster. The Maintenance Director and Dining Director will be responsible to perform regular and random audits of the dumpster area to ensure compliance to this regulatory standard.

The Maintenance Director will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/30/2026)

86b - Bathroom

23. 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 1st floor common bathroom near room 116 does not have an operable window or ventilation fan.

86b - Bathroom *(continued)*

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

The bathroom fan in common area bathroom by 116 was replaced and in operable condition on the afternoon of Day 1 of survey. The Maintenance Director has been trained as to the requirements of this regulation (see attached training). Moving forward, the Maintenance Director or Designee will be responsible to perform regular walk thrus of the community to ensure bathrooms that do not have an operable, outside window are equipped with an exhaust fan for ventilation. The Executive Director will be responsible to perform regular and random audits of community common areas to support compliance to this regulation.

The Maintenance Director and Executive Director will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

88a - Surfaces

24. 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 11/25/25 during the physical site inspection the following items were noted;

- *There are two stained ceiling tiles in the hallway near room 107,*
- *There are three stained ceiling tiles in the hallway near room 210,*
- *The handrail by room 241 is hanging from the wall creating a hazard,*
- *The handrail by room 332 is partially missing, it does not go the full length of the wall.*

- The fire door on the first floor long hallway does not close without manual assistance and the door closer hardware is bent. This was also noted on the home's 09/08/25 fire safety inspection as a noted deficiency.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

The stained ceiling tiles in the hallway near room 107 and three stained ceiling tiles in the hallway near room 210 were replaced on 12/4/25. The handrail by room 241 hanging from the wall and the partially missing handrail by room 332 have been replaced as of 12/30/25. The fire door on the first floor long hallway was repaired and closes without manual assistance and the bent hardware for it has been replaced as of 12/30/25. The Maintenance Director has been trained as to the requirements of this regulation (see attached training). Moving forward, the Maintenance Director or Designee will be responsible to perform regular walk thru of the community to ensure Floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. The Executive Director will be responsible to perform regular and random audits of community common areas to support compliance to this regulation.

The Maintenance Director and Executive Director will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

100a - Exterior - Free of Hazards

25. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The railing for the walkway outside the first floor long hallway exit is severely rusted and chipped with sharp edges making it a hazard.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

The railing outside the 1st floor exit that was severely rusted and chipping of paint was repaired while surveyors were on site during inspection. The Maintenance Director and ED have been trained as to the requirements of this regulation (see attached training). Moving forward, the Maintenance Director or Designee will be responsible to perform regular rounds to the exterior of the building and the building grounds to ensure it is in good repair, free of hazards and compliance to regulatory standards. The Executive Director will be responsible to perform regular and random audits of the exterior to support compliance to this regulation.

The Maintenance Director and Executive Director will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

101j7 - Lighting/Operable Lamp

26. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Residents #3, #9 and #11 do not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

Lighting has been put in place for resident #s 3, 9 and 11. Direct Care and Ancillary Staff, Managers and Executive Director have been trained as to regulatory standard and company policy(see attached training). Going forward, Housekeeping staff will be responsible to ensure compliance to this regulatory standard and will ensure resident rooms have lighting that can be turned on at bedside by performing regular checks during weekly housekeeping.

The ED or Designee will be responsible to perform regular and random audits to ensure compliance to this regulation and report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/30/2026)

101o - Walls, Floors, Ceilings

27. Requirements

2600.

101o - Walls, Floors, Ceilings *(continued)*

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

- The carpet in room #315 is stained by spilled coffee.

- The carpet in room #220 has several stains of unknown origin.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

Resident rooms #315 and 220 have had their carpet cleaned to remove stains. Direct Care and Ancillary Staff, Managers and Executive Director have been trained as to regulatory standard and company policy(see attached training.) Going forward, Housekeeping staff will be responsible to ensure compliance to this regulatory standard and will ensure resident rooms have carpet, walls and ceilings that are finished, clean and in good repair by performing regular checks during weekly housekeeping.

The Maintenance Director will be responsible to perform regular and random audits to ensure compliance to this regulation and report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly. Additionally, for 90 days, the ED will perform random audits and report on the effectiveness of this plan monthly as part of Quality Management.

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

Implemented ([redacted] - 03/30/2026)

124 - Notice to Fire Department

28. 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] - 01/06/2026)***

Notification in writing to the fire department of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency was completed 1/3/26 (see attached documentation). The ED has been trained to this regulatory standard and company policy (see attached training). Going forward, the ED will be responsible to ensure compliance to this regulatory standard and will report as to the effectiveness of this plan quarterly as part of Quality Management throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

132d - Evacuation

29. Requirements

2600.

132d - Evacuation *(continued)*

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

- During the fire drill on 10/25/25 at 12:07 AM, only 59 of the 65 residents in the home at the time were evacuated. Additionally the drill took 29 minutes and 39 seconds exceeding the maximum 15 minute and 0 seconds safe evacuation time as determined by a fire safety expert on September 8, 2025.

- During the fire drill on 10/29/25 at 11:32 PM, the evacuation took 28 minutes and 9 seconds again exceeding the maximum safe evacuation time.

- During the fire drill on 11/26/25 at 1:32 AM, 61 of the 62 residents in the home at the time were evacuated. The resident who did not evacuate was on hospice and was actively dying but the home did not have documentation from a physician indicating the resident was actively dying and may suffer bodily injury or a hastened death as a result of participation in the fire drill.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

The two October 2025 fire drills during the 11p-7a shift exceeded the 15 minute 0 second safe evacuation time established for the community. A fire drill was performed by a Fire Expert during the 11p-7 am shift on 11/26/25 and did meet the safe evacuation time. The RCD and ED have been trained to this regulatory standard and company policy (see attached training). Going forward, the RCD or Designee will be responsible to obtain documentation from a physician indicating a resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in the fire drill and ensure compliance to this regulatory standard.

Additionally, the Maintenance Director will observe 11p-7am fire drills during 2026 to ensure compliance to this regulatory standard and will be responsible to report on the effectiveness of this plan monthly x 90 days and then resume quarterly as part of quality management throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

141a 1-10 Medical Evaluation Information

30. Requirements

2600.

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

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

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

Description of Violation

- Resident #3's medical evaluation, dated [redacted] did not include body positioning and movement stimulation for residents, if appropriate.

- Resident #9's medical evaluation, dated [redacted], did not include the resident's Health Status.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

The DME for Resident #3 has been corrected to include body movement/positioning, and the DME for Resident #9 has been corrected to include Health Status (see attached updated DMEs). The RCD and Executive Director have been trained as to this regulation and company policy (see attached training). The RCD or Designee will be responsible to audit current resident DMEs by 1/22 to ensure compliance to regulatory standards. Going forward, the RCD or Designee will be responsible to ensure the Medical Evaluation is completed as per regulatory standards and provide a review of new admission/significant change/annual DME's completed monthly x 90 days then resume quarterly as part of Quality Management throughout 2026. Additionally, the Executive Director will be responsible to perform audits monthly x 90 days then resume quarterly as part of Quality Management to ensure compliance and evaluate effectiveness of this plan throughout 2026.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented ([redacted] - 03/12/2026)

182b - Prescription Medication

31. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 11/26/25 it was discovered that the home had been using an unauthorized medication technician (Med-Tech) trainer. The home was informed that the Med-Techs trained by this individual are not authorized to administer medications and need to stop immediately. However, the home continued to allow the Med-Techs to administer medications.

- Staff Member G administered the following medications to resident #12 at 9:00 AM on 11/23/25, 11/26/25 and 11/27/25: Atorvastatin Calcium 20 MG Tabs, Depakote Sprinkles 125 MG CSDR, and Donepezil HCL 10 MG Tabs.

- Staff Member H administered these same medications to resident #12 at 9:00 AM on 11/24/25, 11/25/25, 11/28/25, 11/29/25, and 11/30/25.

- Staff Member I administered the following medications to resident #13 at 9:00 AM on 11/28/25; Escitalopram

182b - Prescription Medication (continued)

Oxalate 10 MG Tablet, Florastor 250 MG Oral Capsule, and Lisinopril 5 MG Tablet.

Plan of Correction ***Accept (- 01/06/2026)***

At time of inspection, we were notified by surveyors of non-compliant train the trainer certification through who had conducted med tech certifications for some staff responsible for administering medication to our residents. Staff Member G, H and I were retested, retrained and med observations completed (see attached). The RCD and Executive Director have been trained as to this regulation and company policy (see attached training). Going forward, should we be notified of an unauthorized train the trainer, to ensure compliance to regulatory standards, the affected med techs will be removed from administering medication until such time they are re-certified by an authorized train the trainer. Going forward, the RCD will be responsible to review medication certifications for Staff administering medication monthly x 90 then resume quarterly as part of Quality Management throughout 2026, to ensure compliance to regulatory standards and evaluate effectiveness of this plan.

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

Implemented (- 03/12/2026)

183b - Meds and Syringes Locked

32. Requirements

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

Description of Violation

On 12/01/25 at 12:49 PM, the following medications were unlocked, and accessible in resident #4's room; Tylenol 650 MG, Colace Docusate Sodium 50 MG, Tobramycin Ophthalmic Solution 0.3%, Erythromycin Ophthalmic Ointment 5MG/G, and Curamin Extra Strength. Resident #4 stated these medications are self-administered. Resident #4 is not assessed as being able to self-administer medications.

Repeat Violation: 03/24/25 et. al.

Plan of Correction ***Accept (- 01/06/2026)***

Medication found in resident #4's room was removed at time of survey. The RCD, Managers and staff in Housekeeping, Maintenance and Direct Care have been trained as to this regulation and company policy (see attached training). Going forward, the housekeeping staff and direct care staff will be responsible to report to the RCD, ARCD or ED any medications found in resident rooms that is not in an area or container locked and in compliance with regulatory standard. Housekeeping staff will audit resident rooms during routine housekeeping to ensure compliance and the RCD or Designee will be responsible to perform regular and random audits to ensure compliance to regulatory standards.

The RCD or Designee will be responsible to report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

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

Implemented (- 03/30/2026)

183d - Prescription Current

33. 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 11/26/25, Triamcinolone Acetonide 0.1% external Ointment with a discard date of 08/14/25 on the pharmacy label prescribed for individual #14, was in the home's short hall medication cart.

- On 11/26/25, Milk of Magnesia 400 MG/5 ML with a discard date of 04/05/25 on the pharmacy label prescribed for individual #15, was in the home's short hall medication cart.

Repeat Violation: 03/24/25 et. al.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

Expired meds for residents #14 and #15 were removed from the medication cart at time of survey. Audits of medication carts were completed on 1/3/26. The 11-7 LPN/Med Techs, RCD and ED have been trained as to this regulatory standard and company policy (see attached training). Going forward, the 11-7 LPN/Medtechs will be responsible to perform regular med cart audits on the 11-7 shift to ensure compliance to this regulatory standard. T

The RCD will be responsible to review med cart audits to ensure compliance to this regulation and will report monthly as part of Quality Management on the effectiveness of this plan x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/30/2026)

185a - Implement Storage Procedures

34. 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 11/26/25 at 3:00 PM, resident #11's glucometer displayed the time as 4:01 PM.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

Glucometers were recalibrated to ensure correct dates/times during inspection. RCD, ED and medication staff have been trained as to this regulatory standard and company policy (see attached training). Going forward, the 11-7 LPN/Medtech will be responsible to audit current glucometers daily to ensure appropriate documentation for readings to ensure compliance to this regulatory standard.

Additionally, the RCD will be responsible to perform regular audits to ensure compliance to this regulation and will report monthly as part of Quality Management on the effectiveness of this plan x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

35. Requirements

185a - Implement Storage Procedures *(continued)*

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 #13 is prescribed Clonazepam 0.25 MG Oral Tablet Disintegrating - Take one tablet by mouth daily at bedtime. The home's Controlled Substance Management policy and procedures require the date, time, quantity used, quantity remaining and staff initials be documented on the Controlled Drug Receipt/Record/Disposition Form at the time of administration. Between the dates of 11/11/25 and 11/13/25, a pill was administered at 8:00 PM. The date is not listed on the log.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

RCD, ED and medication staff have been trained as to this regulatory standard and company policy (see attached training). Going forward, the 11-7 LPN/Medtech will be responsible to audit the Controlled Drug Disposition Form to ensure compliance to this regulatory standard.

Additionally, the RCD will be responsible to perform regular audits to ensure compliance to this regulation and will report monthly as part of Quality Management on the effectiveness of this plan x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

36. 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 11/15/25, the 4:00 PM Accucheck reading is listed as 338 on resident #13's November 2025 Medication Administration Record (MAR); however, resident #13's glucometer reading for this date and time is 355. Additionally, on 11/16/25 at the 4:00 PM time slot, 331 is recorded on the MAR and the resident's glucometer reads 312 for this time slot.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

RCD, ED and medication staff have been trained as to this regulatory standard and company policy (see attached training). Going forward, the 11-7 LPN/Medtech will be responsible to audit current glucometers to ensure appropriate documentation for readings and audit applicable resident MARS daily to ensure compliance to this regulatory standard.

Additionally, the RCD will be responsible to perform regular audits to ensure compliance to this regulation and will report monthly as part of Quality Management on the effectiveness of this plan x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

187a - Medication Record

37. Requirements

187a - Medication Record *(continued)*

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #13 is prescribed Lantus Solostar 100 Unit/ML Injection - Inject 10 unit(s) subcutaneously every night at bedtime. This medication was administered on 11/12/25; however, the initials of the staff person who administered the medication is not included on resident #13's medication administration record.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

RCD, ED and medication staff have been trained as to this regulatory standard and company policy (see attached training). Going forward, med staff will be responsible to perform individual audits at shift change to ensure initials, dates and times are documented on the Medication Administration Record for medication administered during their shift.

The RCD will be responsible to perform regular audits to ensure compliance to this regulation and will report monthly as part of Quality Management on the effectiveness of this plan x 90 days then resume quarterly throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

187b - Date/Time of Medication Admin.

38. 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 #13 is prescribed Clonazepam 0.25 MG Oral Tablet Disintegrating - Take one tablet daily at bedtime, Hydralazine HCL 25 MG Oral Tablet - Take one tablet four times a day with food, and Quetiapine Fumarate 25 MG Tabs - One tab by mouth daily at bedtime. Resident #13's November 2025 medication administration record does not include the initials of the staff person who administered these medications on the evening of 11/12/25.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

RCD, ED and medication staff have been trained as to this regulatory standard and company policy (see attached training). Going forward, medication staff will be responsible to perform individual audits at shift change to ensure

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

initials, dates and times are documented on the Medication Administration Record for medication administered during their shift.

The RCD will be responsible to perform regular audits to ensure compliance to this regulation and will report monthly as part of Quality Management on the effectiveness of this plan x 90 days then resume quarterly throughout 2026.

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

Implemented (- 03/12/2026)

187d - Follow Prescriber's Orders

39. Requirements

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

Description of Violation

- Resident #13 is prescribed Accucheck - Check blood glucose three times daily before oral medications. The times listed on resident #13's November 2025 MAR are listed as 9:00 AM, 11:00 AM and 4:00 PM. However, resident #13's blood glucose checks were completed at 12:51 PM on 11/24/25 reading 143, at 12:29 PM on 11/25/25 reading 81, and at 12:36 PM on 11/26/25 reading 218.

- Resident #13 is also prescribed an Accucheck - Check blood glucose as needed. According to resident #13's glucometer, a reading was taken at 9:00 PM on 11/12/25 but this reading was not documented on the resident's November 2025 MAR.

Plan of Correction ***Accept (- 01/06/2026)***

The RCD, ED and medication staff have been trained as to this regulatory standard and company policy (see attached training). At time order received the RCD/designee will assure that the times to complete blood glucose checks match current physician order. Going forward, the 11-7 LPN/Medtech will be responsible to perform a daily audit to ensure appropriate documentation for readings and ensure the MAR contains proper documentation in compliance to regulatory standards.

The RCD/designee will be responsible to perform regular, random audits to ensure compliance to this regulation and will report monthly as part of Quality Management on the effectiveness of this plan x 90 days then resume quarterly throughout 2026.

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

Implemented (- 03/12/2026)

191 - Resident Right to Refuse

40. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

191 - Resident Right to Refuse *(continued)*

Description of Violation

- Resident #3, admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

- Resident #6, admitted [redacted], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

A signed statement acknowledging receipt of resident rights that addresses education of a Resident Right to Refuse Medication was obtained at contract signing for resident #3, but was not dated (see attached acknowledgment) and for resident #6 [redacted] signed [redacted] as the Resident (see attached acknowledgment). A corrected statement for resident #3 will be obtained by 1/10/26. Resident #6 no longer resides at the community. An audit of current resident contracts has been completed to identify any missing or incorrect resident right acknowledgements. Any required resident signatures will be obtained by 1/22 as it relates to this violation. ED/BOM were trained as to this regulation and company policy (see attached training). Going forward, the Executive Director, BOM or Designee will be responsible to ensure resident signatures are obtained to ensure compliance with this regulatory standard.

The BOM will be responsible to perform monthly audits as part of Quality Management and report on the effectiveness of this plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026. Additionally, for 90 days, the Executive Director or Designee will be responsible to perform monthly audits as part of Quality Management to ensure compliance with this regulatory standard.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented ([redacted] - 03/12/2026)

224a - Preadmission Screen Form

41. Requirements

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

Description of Violation

- Resident #1's preadmission screening form, dated [redacted] does not include a determination that the needs of the resident can be met by the services provided by the home.

- Resident #6's preadmission screening form, dated [redacted] does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

RCD, ED and BOM have been trained as to this regulatory standard and company policy (see attached training). An audit of current resident preadmission screen forms will be completed by 1/22 to identify any missing determination that the needs of the resident can be met by the services provided by the home. Going forward, the RCD will be responsible to ensure compliance to this regulatory standard and will audit the preadmission screen form upon resident admission. Additionally, for 90 days, the ED will be responsible to audit preadmission screen forms as part

224a - Preadmission Screen Form (continued)

of the admission process to ensure compliance, then resume quarterly with random audits to ensure effectiveness of this plan as part of Quality Management throughout 2026.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented (- 03/12/2026)

225c - Additional Assessment

42. 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 #2's current assessment was completed on However, the resident's previous assessment was completed on Additionally, the resident has shown aggression towards staff on multiple occasions; however, there is no "need" identified in the resident's RASP regarding Irritability, Agitation or Aggression.

- Resident #4's current assessment was completed on . However, the resident's previous assessment was completed on

- Resident #16's assessment, dated does not include that the resident is receiving hospice services.

Plan of Correction ***Accept (- 01/06/2026)***

Residents #2, #4 and #16 no longer reside at the Community. RCD has been trained on regulation and company policy (see attached). An audit of current resident assessments was in process prior to survey (see attached audit). Any additional RASPS for completion will be identified and addressed accordingly by 1/22. Moving forward, the RCD/designee will ensure that each resident has an initial written assessment within 15 days of move-in to meet regulatory standard. For 60 days, beginning 1/1/2026, the Executive Director (ED) will complete an audit of new admissions, within 15 days of move-in to assure that an initial assessment has been completed as per regulatory standards.

The ED will be responsible to report on the effectiveness of this plan monthly x 60 days then resume quarterly as part of Quality Management throughout 2026.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented (- 03/12/2026)

227d - Support Plan Medical/Dental

43. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

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

Description of Violation

- The assessment for resident #4, dated [redacted], indicates the resident needs total physical assistance with Transferring in/out bed/chair and turning and positioning in bed/chair. However the plan to meet this need is not completed. The resident does have a bedside mobility device but that is not included on the RASP.

- The assessment for resident #5, dated [redacted] indicates the resident needs no physical assistance with Transferring in/out bed/chair or Turning and positioning in bed/chair. The resident does have a bedside mobility device but that is not included on the RASP.

- The assessment for resident #13, dated [redacted] indicates the resident needs some physical assistance with Transferring in/out bed/chair with nursing staff to assist resident as needed with transfers into/out of bed/wheelchair. The assessment also lists that the resident needs no assistance with turning and positioning in bed/chair. The resident does have a bedside mobility device but that is not included on the RASP.

When such devices are in use, the Resident Support Plan must reflect:

- *The specific need for the device,*
- *The intended Use,*
- *Any risks associated with the device,*
- *The resident's ability to use the device safely for the intended purpose,*
- *Identification of the specific device to be used,*
- *If a cover is required to meet FDA guidelines.*

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

Resident #4 no longer resides at the community. RASPS for residents #5 and #13 have been reviewed and updated to include bedside mobility (see attached RASPS). An audit of current resident RASPs requiring enabling devices will be completed by 1/22 and updated accordingly. RCD has been trained on regulation requirements and company policy (see attached training). Moving forward, the RCD/designee will ensure that new and updated RASPs address the use of enabling devices, when appropriate, to meet regulatory standards. For 60 days, starting 1/5/2026, the ED/Designee will complete regular, random audits of new and current RASPs to assure they appropriately address enabling devices when appropriate. The ED/Designee will be responsible to report on the effectiveness of this plan monthly x 60 days then resume quarterly as part of Quality Management throughout 2026.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented ([redacted] - 03/12/2026)

227g -Support Plan Signatures

44. 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 #2 participated in the development of their support plan on [redacted] However, the resident did not sign the support plan.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

Resident #2 no longer resides at the community. RCD has been trained on regulation and company policy (see

227g -Support Plan Signatures (continued)

attached). An audit of current resident support plans was in process prior to survey (see attached audit). Remaining audits to identify Support Plans with missing signatures and updated with appropriate documentation of signatures by 1/22. Going forward, the RCD/Designee will be responsible to obtain appropriate signature documentation on support plans to ensure compliance to this regulatory standard. The ED/Designee will be responsible to perform monthly audits and report on the effectiveness of the plan as part of Quality Management monthly x 90 days then resume quarterly throughout 2026.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented (- 03/12/2026)

234a - Admission Support Plan

45. Requirements

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

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on . However, the resident's initial support plan was completed on

Plan of Correction ***Accept (- 01/06/2026)***

RCD and ED have been trained as to this regulation and company policy (see attached training). Going forward, the RCD will be responsible to develop, implement and document a support plan within 72 hours of admission for any resident admission to the SDCU and ensure compliance to this regulatory standard. The ED or Designee will be responsible to audit the support plan for any SDCU admissions for 60 days, then resume quarterly throughout 2026 with regular audits as part of Quality Management to ensure effectiveness of this plan.

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

Implemented (- 03/12/2026)

235 - Discharge/Transfer/Closure

46. Requirements

2600.
235. Discharge - If the home initiates a discharge or transfer of a resident, or the legal entity chooses to close the home, the administrator shall give a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This requirement shall be stipulated in the resident-home contract signed prior to admission to the secured dementia care unit.

Description of Violation

On , the home initiated an emergency discharge of resident #2 persuant to the executed Residency Agreement signed by responsible parties that the home may terminate this Agreement with less than 30 day discharge due to the health, safety or well-being of you or others in the Community. However, the home's Residence and Care Agreement, under section VIII.B.2a regarding termination Upon Less than Thirty (30) Calendar Days' Notice states "A delay in your discharge or transfer would jeopardize the health, safety or well-being of you or others in the Community, as certified by a physician or the Department of Human Services." The home did not obtain certification from a physician or the Department of Human Services.

Plan of Correction ***Accept (- 01/06/2026)***

RCD, ED and BOM have been trained to this regulatory standard and company policy (see attached training).

235 - Discharge/Transfer/Closure (continued)

Going forward, the ED or Designee will be responsible to obtain certification from a physician or the Department of Human Services for any determination to discharge without a 30 day notice as per the Homes contract and ensure compliance to this regulatory standard.

The ED will be responsible to report as to the effectiveness of this plan monthly x 90 days then resume quarterly as part of Quality Management throughout 2026.

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

Implemented ([redacted] - 03/12/2026)

252 - Record Content

47. Requirements

2600.

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

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

252 - Record Content *(continued)*

Description of Violation

Resident #13's record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Accept ([redacted] - 01/06/2026)***

A current picture for resident #13 was obtained and added to the resident record during inspection. The RCD, ED, Programming Director and BOM have been trained to this regulatory standard and company policy (see attached training). An audit of all resident pictures to ensure they are no more than 2 years old was completed on 12/23/25 and updated pictures necessary for compliance to this regulatory standard were obtained and added to the resident record. Going forward, the RCD or Designee will be responsible to ensure compliance to this regulatory standard by implementing an annual "picture day" to be completed by 2/28/26 and established annually thereafter.

The ED will be responsible to report quarterly on the effectiveness of this plan as part of Quality Management throughout 2026.

Proposed Overall Completion Date: 02/28/2026

Licensee's Proposed Overall Completion Date: *01/30/2026*

Implemented ([redacted] - 03/12/2026)