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

May 28, 2026

[redacted], REGIONAL DIRECTOR OF OPERATIONS
RAPPS SENIOR CARE LLC
[redacted]

RE: WOODBRIDGE PLACE
1191 RAPPS DAM ROAD
PHOENIXVILLE, PA, 19460
LICENSE/COC#: 14359

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, 12/22/2025 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: *WOODBRIDGE PLACE* **License #**: *14359* **License Expiration**: *12/21/2025*

Address: *1191 RAPPS DAM ROAD, PHOENIXVILLE, PA 19460*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *RAPPS SENIOR CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/17/1996* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *116* **Waking Staff**: *87*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *12/22/2025*

Inspection Dates and Department Representative

11/25/2025 - On-Site: [redacted]

11/26/2025 - On-Site: [redacted]

12/22/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served**: *89*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *21* **Residents Served**: *20*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *89*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *27*

Have Physical Disability: *0*

Inspections / Reviews

11/25/2025 Full

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

Inspections / Reviews *(continued)*

01/26/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/26/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *01/31/2026*

02/05/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/26/2026*

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

05/28/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/26/2026*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

34 Pa.Code Chapter 3, known as the Boilers and Unfired Pressure Vessels regulations. (governed by Department of Labor and Industry). If a home has a boiler, it must have a valid "Certificate of Boiler or Pressure Vessel Operation" issued by the PA Department of Labor and Industry. Upon expiration of the certificate, boilers must be inspected, and if they pass inspection, they will be issued a new certificate. The home's boiler certificate expired 08/15/2025 and the boiler was inspected on 11/17/2025 but the new certificate is not available on 11/26/2025.

Plan of Correction ***Accept ([redacted] - 02/05/2026)***

Boiler #2 inspection certificate has been received. Please see attached.
Inspection scheduling reminders will be established at 9/1/2027, 10/1/2027, and 11/1/2027 days prior to 2 year certificate expiration to ensure inspections occur well before expiration of 12/11/2027. Responsibility for tracking boiler certification and inspections will be assigned to the Maintenance Director/Administrator or designee.
As part of ongoing facility oversight, the Administrator or designee will review critical safety certifications, including boiler certificates, during routine compliance reviews conducted monthly. Next compliance review to take place 1/30/2026.

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented ([redacted] - 05/28/2026)

42b - Abuse

2. Requirements

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

Description of Violation

Resident #1's progress notes indicate that [redacted] has been verbally and physically aggressive towards staff and other residents. Resident #2's progress notes show that [redacted] wanders in and out of other residents' rooms and displays aggressive behaviors such as punching and/or swinging at staff during assistance.
On 11/12/2025 around dinner time, resident #2 wandered around the home's Secured Dementia Care Unit (SDCU) despite staff A's redirection effort. When resident #1, who was sitting at the dining table, spotted resident #2 standing in front of [redacted] room which was about 8 feet away from where the resident was sitting, resident #1 rushed to resident #2 yelling and screaming "Get away from my room." Before staff A could remove resident #2 from the doorway, resident #1 hit resident #2 with [redacted] walker about 3 times on the chest and then resident #2 punched resident #1 in the face. Resident #1 sustained [redacted] resident #2 sustained [redacted] Both residents were sent out to a hospital for 72 hour observation but they returned early in the morning next day without any new orders.

Repeat Violation: 06/02/2025

42b Abuse *(continued)*

Plan of Correction ***Directed ([redacted] - 02/05/2026)***

Memory Care Direct Care Staff immediately intervened to separate Resident #1 and Resident #2 once the incident occurred. Both residents were assessed for injuries and sent to the hospital for 72 hour observation as a precaution. Incident reports were completed, and the Administrator was notified in accordance with facility policy. Incident was self reported to local Area on Aging and DHS within 24 hours of occurrence. Upon return to the facility, both residents were reassessed to ensure there were no changes in condition or new medical orders required.
On 11/12/2025 Memory Staff were instructed by DOW of the requirement to provide close supervision and immediate intervention to prevent resident to resident altercations.
Enhanced supervision was implemented 11/13/2025 for both residents, particularly during high risk times such as meals and transitions. Memory Care Direct Care Staff were instructed to immediately remove wandering residents from other residents' room areas to prevent territorial or reactive behaviors. Staffing patterns in the SDCU were reviewed by Administrator/DOW to ensure adequate coverage during peak activity times.
On 11/13/2025 all direct care staff received retraining on resident rights, abuse prevention, dementia related behaviors, de escalation techniques, and resident to resident altercation prevention. See attached.
Effective 11/25/2025 the Administrator and DOW will review incident reports and 10 support plans monthly to identify trends and implement additional corrective actions as needed. This review will continue from 11/25/2025 through April 1, 2026.
On 12/04/2025 Resident #1 and Resident #2 care plans were reviewed by Administrator and DOW and updated by DOW to address aggressive behaviors, wandering, and known triggers. See attached.

Proposed Overall Completion Date: 01/27/2026

Directed Plan of Correction ([redacted] - 2/5/26):

In addition to the above plan of correction, starting 5 days from the receipt of the acceptable plan of correction, the administrator or designee shall observe staff/resident interactions, during congregate meals, at least three times per week for two months to ensure supervision of residents is adequately provided. Documentation of observations shall be maintained.

Directed Completion Date: *02/25/2026*

Implemented ([redacted] - 05/28/2026)

65f - Training Topics

3. Requirements

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

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

65f - Training Topics *(continued)*

Description of Violation

Direct care staff person B did not receive training in (2) 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: 06/02/2025

Plan of Correction ***Directed ([redacted] - 02/05/2026)***

On 11/26/2025 it was documented in staff person B's employment file that upon annual survey it was discovered missing training in (2) 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. See attached.
New annual training calendar was posted on 1/1/2026.
Business Office Director to resume and maintain the audit of training of staff monthly beginning on November 25, 2025 through March 31, 2026 to verify monthly training completion compliance and findings to be reported to and reviewed during monthly Quality Assurance meeting held 1/30/2026. See attached.
A full audit of all staff annual trainings for 2024 and 2025 to be completed by 2/27/2026. All remedial trainings for all staff 'to be completed by 3/30/2026.

Proposed Overall Completion Date: 01/27/2026

Directed Plan of Correction ([redacted] - 2/5/26):

Within 5 days of the receipt of the acceptable plan of correction, staff B shall be re-trained in the missed topics under the supervision of the administrator or designee.

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall complete a full audit of employee records to ensure no training topics have been missed for the 2024 or 2025 training years. Remedial trainings shall be completed and supervised by the administrator or designee within 20 days.

Directed Completion Date: *02/25/2026*

Implemented ([redacted] - 05/28/2026)

65g - Annual Training Content

4. 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 B did not receive training in (1) Fire safety completed by a fire safety expert or by a staff person trained

65g - Annual Training Content (continued)

by a fire safety expert during training year 2024.

Repeat Violation: 07/31/2025, 06/02/2025

Plan of Correction ***Directed (- 02/05/2026)***

On 11/26/2025 it was documented in staff person B's employment file that upon annual survey it was discovered missing training in (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year 2024. See attached.
New annual training calendar was posted on 1/1/2026.
Business Office Director to resume and maintain the audit of training of staff monthly beginning on November 25, 2025 through March 31, 2026 to verify monthly training completion compliance and findings to be reported to and reviewed during monthly Quality Assurance meeting held 1/30/2026. See attached.
A full audit of all staff annual trainings for 2024 and 2025 to be completed by 2/27/2026. All remedial trainings for all staff 'to be completed by 3/30/2026.

Proposed Overall Completion Date: 01/27/2026

Directed Plan of Correction (- 2/5/26):

Within 5 days of the receipt of the acceptable plan of correction, staff B shall be re-trained in the missed topics under the supervision of the administrator or designee.

In addition to the above plan of correction, within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall complete a full audit of employee records to ensure no training topics have been missed for the 2024 or 2025 training years. Remedial trainings shall be completed and supervised by the administrator or designee within 20 days.

Directed Completion Date: *01/27/2026*

Implemented (- 05/28/2026)

81b - Resident Personal Equipment

5. 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 #3's bed is equipped with a bedside mobility device, which was laid between the bed and the mattress but not secured to the bed frame and could easily be pulled out. Bedside mobility devices that slide under the mattress and are not securely attached to the structure of the bed can move and create entrapment zones not always present upon inspection. These types of devices are not permitted under any circumstances.

Plan of Correction ***Accept (- 02/05/2026)***

Bedside mobility device for Resident #3 was immediately removed upon discovery of use.
On 12/1/2025 a facility-wide inspection of resident beds and assistive devices was conducted by Administrator and

81b - Resident Personal Equipment (continued)

DOW to ensure no prohibited or unsafe equipment is in use. Audit tool was created and continues to be updated weekly by the DOW through April 1, 2026. See attached.
Direct care staff, Supervisors, Housekeeping, and Maintenance staff received retraining on 12/1/2025 from Administrator on resident equipment safety, entrapment risks, and prohibited devices, including under-mattress bedside mobility devices. See attached.
Maintenance Director or designee to conduct monthly bed rail and assistive device compliance audit for continued compliance.
The Administrator or designee will review once monthly bed rail and assistive device audit to ensure continued compliance with § 2600.81(b) effective 12/1/2025 through April 1, 2026.

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented ([redacted] - 05/28/2026)

101j7 - Lighting/Operable Lamp

6. Requirements

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

Description of Violation

Resident #4 in resident room [redacted] does not have access to a source of light that can be turned on/off at bedside.

Repeat Violation: 12/30/2024

Plan of Correction ***Accept ([redacted] - 01/26/2026)***

Resident #4's lamp was immediately plugged back in upon discovery of it being unplugged.
The Maintenance Director, Administrator or designee will conduct routine environmental and equipment safety audits to ensure continued compliance with § 2600.101(j) effective 12/1/2025 through April 1, 2026. See attached.

Licensee's Proposed Overall Completion Date: *01/23/2026*

Implemented ([redacted] - 05/28/2026)

107c - Food/Water 3 Day Supply

7. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 11/25/2025, the home served 89 residents, requiring 267 gallons of emergency drinking water. However, the home had only 116 gallons. The home's emergency water contract with US Foods says that each resident needs 1/2 gallon (64 oz) per day, which does not meet the department's recommended 1 gallon per person per day requirement.

Plan of Correction ***Accept ([redacted] - 01/26/2026)***

On 11/26/2025, an audit of the emergency water supply was conducted.
The emergency water supply was in compliance with regulation 2600.107.c as of 12/2/2025.
Effective immediately, the Culinary Services Director or [redacted] designee will conduct a monthly audit of the

107c - Food/Water 3 Day Supply (continued)

emergency food and water supply. This audit will begin on 12/1/2025 and continue through April 1, 2026.

Licensee's Proposed Overall Completion Date: *01/23/2026*

Implemented ([redacted] - 05/28/2026)

132f - Alternate Exit Routes

8. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

All exits were used during the fire drills held on 08/20/2025, 10/16/2025, and 11/19/2025.

Plan of Correction ***Accept ([redacted] - 01/26/2026)***

Croker Fire Safety Corporation has been formally made aware of the violation as of 1/19/2026. [redacted] from Croker Fire and Safety is currently working to resolve the violation issue with DHS. An email from [redacted] of Croker was sent to the State 1/15/2026 and is pending a response.
Effective 1/7/2026 fire inspectors from Croker are notified by Maintenance Director prior to a fire drill that alternate exits must be used for each drill.
Administrator will review fire drills quarterly to ensure that alternate exits are being used.
1/7/2026 Administrator in-serviced Maintenance Director on proper documentation of Fire Drill record in accordance with 2600.132.f.

Licensee's Proposed Overall Completion Date: *01/23/2026*

Implemented ([redacted] - 05/28/2026)

183e - Storing Medications

9. Requirements

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

Description of Violation

On 11/26/2025, an opened Ozempic prefilled pen prescribed for resident #5 was in the home's 1st floor medication cart without an open/discard after date indicated. According to the manufacturer's instructions, the pen should be discarded 56 days after first use.

Repeat Violation: 07/31/2025, 10/23/2024

Plan of Correction ***Accept ([redacted] - 01/26/2026)***

Resident #5's Ozempic pen was immediately ordered from the pharmacy and arrived by the next business day. An open date was put on the Ozempic pen for compliance.
Administrator held in-service for all nurses regarding 2600.183.e on 12/3/2025.
Continued weekly cart audits to be conducted by DOW or [redacted] designee to ensure compliance of all medications

183e Storing Medications (continued)

being dated when opened and discarded according to manufacturer's instructions.
Weekly med cart audits, x3 months will be put in place starting January 1, 2026, through April 1, 2026. (All audits and in services will be maintained and ready for the Department to review upon request).

Licensee's Proposed Overall Completion Date: *01/23/2026*

Implemented ([redacted] - 05/28/2026)

185a - Implement Storage Procedures

10. 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 #6 is prescribed Docusate Sodium 100 MG soft capsules as needed. On 11/26/2025, this medication was not available in the home.

Repeat Violation: 07/31/2025, 06/02/2025

Plan of Correction ***Accept ([redacted] - 01/26/2026)***

Resident #6's prescribed Docusate Sodium 100 mg soft capsules were immediately ordered from the pharmacy and arrived by the next business day.
12/3/2025 DOW conducted in service to med techs and nurses regarding regulation 2600.185.a.
Continued weekly cart audits to be conducted by DOW or [redacted] designee to ensure compliance of all PRN medications availability.
Weekly med cart audits, x3 months will be put in place starting January 1, 2026, through April 1, 2026. (All audits and in services will be maintained and ready for the Department to review upon request).

Licensee's Proposed Overall Completion Date: *01/23/2026*

Implemented ([redacted] - 05/28/2026)

11. 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 #5 is prescribed Morphine O/Syr 10 mg/0.5 ml every two hours as needed (PRN). On 11/26/2025 around 10:50 AM, there were only 87 syringes left while the controlled medication log indicated 88 as the remaining balance after 05:47 AM on 11/26/2025 administration. Staff administering this PRN medication between 05:47 AM and 10:50 AM did not follow the home's controlled medication distribution policy, which requires documenting the date, time, staff name administering dose, and balance remaining.

Repeat Violation: 07/31/2025, 06/02/2025

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept ([redacted] - 02/05/2026)***

On 12/3/2025 an in-service was conducted by DOW with all medication technicians and nursing staff regarding proper documentation of controlled substances.
Continued weekly medication cart audits that include review of MAR and Narcotic logs to be conducted by DOW or [redacted] designee to ensure compliance of all PRN medications availability and documentation of administration.
Weekly med cart audits, x3 months will be put in place starting January 1, 2026, through April 1, 2026. (All audits and in-services will be maintained and ready for the Department to review upon request).

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented ([redacted] - 05/28/2026)

187b - Date/Time of Medication Admin.

12. 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 #5 is prescribed Morphine every two hours as needed. The resident's November MAR does not include the initials of staff person C who administered it on 11/26/2025 at 00:54 AM and 05:47 AM.

Repeat Violation: 10/23/2024

Plan of Correction ***Accept ([redacted] - 02/05/2026)***

On 12/3/2025 an in-service was conducted by DOW with all medication technicians and nursing staff regarding proper recording of documentation at the time of administration.
Continued weekly medication cart audits that include review of MAR and Narcotic logs to be conducted by DOW or [redacted] designee to ensure compliance of all PRN medications availability and documentation of administration.
Weekly med cart audits, x3 months will be put in place starting January 1, 2026, through April 1, 2026. (All audits and in-services will be maintained and ready for the Department to review upon request).

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented ([redacted] - 05/28/2026)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident #1 is prescribed Insulin Lispro injection four times a day per sliding scale: 2 units BSG 200~250, 4 units BSG 251~300, 6 units BSG 301~350, 8 units BSG 351~400, call MD if BSG is over 401 or below 70. On 11/20/2025 08:00 AM, the resident's blood sugar reading was 326, which requires 6 units but the resident was administered 8 units. On 11/16/2025 at 12:00 PM, the resident's glucometer did not have a reading but it was documented as 197, which

187d Follow Prescriber's Orders (continued)

requires none but the resident was administered 2 units.

Repeat Violation: 07/31/2025, 12/30/2024, 10/23/2024

Plan of Correction ***Directed (- 02/05/2026)***

On 12/1/2025 an in service was conducted by the DOW with all medication technicians and nursing staff regarding following prescribers directions for medication administration.
Resident #1 discharged from the community on
Medication error identified after discharge.
By 1/30/2026 all medication technicians and nursing staff to complete training on medication errors and proper reporting.
Continued weekly cart audits to be conducted by DOW or designee to ensure compliance of all MAR documentation, glucometer logs and medication administration recordings.
Weekly med cart audits, x3 months will be put in place starting January 1, 2026, through April 1, 2026. (All audits and in services will be maintained and ready for the Department to review upon request).

Proposed Overall Completion Date: 01/27/2026

Directed Plan of Correction (- 2/5/26):

To clarify, and in addition to the above plan of correction, the administrator or designee shall audit glucometers and documentation of blood glucose readings in the planned audits (weekly for three months) to ensure the proper amount of insulin is administered. The home shall specifically audit residents that require blood glucose monitoring and sliding scale insulin administration

Directed Completion Date: *01/27/2026*

Implemented (- 05/28/2026)

225c - Additional Assessment

14. 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 #3's bed was observed with a bedside mobility device. However, the resident's status change assessment, dated does not include

- *The specific need for the device*
- *The intended use and any risks associated with the use*
- *The resident's ability to use the device safely for the purpose it was intended*
- *Identification of the specific device to be used and whether a cover is required to meet FDA guidelines.*

225c Additional Assessment (continued)

Repeat Violation: 10/23/2024

Plan of Correction ***Directed ([redacted] - 02/05/2026)***

On 12/1/2025 a facility wide inspection of resident beds and assistive devices was conducted by Administrator and DOW to ensure no prohibited or unsafe equipment is in use. Audit tool was created 12/1/2025 and continues to be updated weekly by DOW or [redacted] designee. This audit will be in effect from 12/1/2025 through 4/1/2026.
On 12/3/2025 Direct care staff received retraining by the DOW on resident equipment safety, entrapment risks, and prohibited devices, including under mattress bedside mobility devices.
The Administrator or designee will conduct once monthly environmental and equipment safety audits to ensure continued compliance with § 2600.81(b) effective 12/1/2025 through April 1, 2026.(All audits and in services will be maintained and ready for the Department to review upon request).
Resident #3's RASP was reviewed by DOW and is current as of 12/1/2025. The bed mobility device was immediately removed 11/25/2025. Resident educated regarding reason for removal on 11/25/2025 by DOW.
In addition to audit initiated on 12/1/2025 of RASPs of residents with bed mobility devices reviewed by Administrator and DOW and are current and reflect all requirements.

Proposed Overall Completion Date: 01/27/2026

Directed Plan of Correction ([redacted] - 2/5/26):

In addition to the above plan of correction, within 5 days of the receipt of the acceptable plan of correction, the administrator or designee shall perform a monthly audit of all residents who utilize bedside mobility devices to ensure that the assessment and support plan is updated with all required information, to include the following:

- *The specific need for the device*
- *The intended use of the device*
- *Any risks associated with the device*
- *The resident's ability to use the devices safely for the intended purpose*
- *identification of the specific device to be use*
- *if a cover is required to meet FDA guidelines*

Directed Completion Date: *02/11/2026*

Implemented ([redacted] - 05/28/2026)

227g -Support Plan Signatures

15. Requirements

2600.

227g -Support Plan Signatures *(continued)*

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

Description of Violation

Resident #7 participated in the development of [redacted] support plan on [redacted] However, the resident did not sign the support plan.

Repeat Violation: 07/31/2025, 06/02/2025, 03/24/2025

Plan of Correction ***Accept ([redacted] - 02/05/2026)***

Effective 12/1/2025 an audit of all support plans was initiated by the Administrator and DOW to ensure compliance of regulation 2600.227.g Individuals who participate in the development of the support plan shall sign and date the support plan.
This audit will remain in effect through April 1, 2026.
An in-service was held on 12/1/25 by the DOW, for all nursing staff regarding the importance of the residents' signature to be on the care plan or their family member after they have participated in the plan. This in-service is available upon request.
Resident #7 signed the RASP 12/1/2025.
Effective as of 1/26/2026 Administrator or designee to review and verify appropriate signatures on all new residents and updated RASPs monthly through 4/1/2026.

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented ([redacted] - 05/28/2026)

231c - Preadmission Screening

16. 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 #1 was admitted to the Secured Dementia Care Unit (SDCU) on [redacted]. The resident's written cognitive preadmission screening completed on [redacted] does not indicate the diagnosis of dementia, Alzheimer's, or cognitive impairment. The diagnosis was listed as depression/anxiety.

Repeat Violation: 06/02/2025, 01/29/2025

Plan of Correction ***Accept ([redacted] - 02/05/2026)***

Resident #1's Prescreen was reviewed and noted that the dementia diagnosis was not listed in the cognitive screen portion of the Prescreen form. It was documented on the prescreen form that this violation was found upon the annual survey November 25, 2025.
An audit was initiated 12/1/2025 and completed on 1/27/2026 of all memory care prescreens by the Administrator and DOW. Audit of memory care prescreens to be completed monthly through April 1, 2026 and will be available for review upon request.

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented ([redacted] - 05/28/2026)

234a - Admission Support Plan

17. 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 #1 was admitted to the Secured Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted]
Resident #6 was admitted to the Secured Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted]

Repeat Violation: 06/02/2025

Plan of Correction ***Accept ([redacted] - 01/26/2026)***

On 12/23/25, DOW and nursing staff in-serviced by ED on regulation 234a. and the importance of obtaining compliance with the initial support plans and the timing of when they are completed. All of the memory care support plans were audited on 12/23/2025 by the DOW to ensure compliance with the date completed upon move in. To maintain compliance with support plans, DOW or [redacted] designee will audit 1 time per month any new move ins to the SDU, and their support plan date to ensure it is within 72 hours. This audit will be in place until 4/1/26. (All audits and in-services will be maintained and ready for the Department to review upon request).

Licensee's Proposed Overall Completion Date: *01/23/2026*

Implemented ([redacted] - 05/28/2026)

234d - Support Plan Revision

18. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #1's progress notes indicate that [redacted] has been verbally and physically aggressive towards staff and other residents. However, resident #1's support plan updated/completed on [redacted] does not reflect the resident's aggression at all.
Since [redacted] admission to the home's SDCU on [redacted] resident #2 has displayed aggressive behaviors such as punching and/or swinging at staff during assistance. The support plan for resident #2 was completed on [redacted] but it has not been updated with [redacted] behavioral expressions.

Plan of Correction ***Accept ([redacted] - 02/05/2026)***

On 12/4/2025 the Administrator and DOW reviewed the progress notes and behavioral documentation for Resident #1 and Resident #2. Both residents' support plans were revised to include documented aggressive behaviors, identified triggers, and appropriate interventions. Direct care staff were informed of the updated support plans and instructed to follow the revised interventions as of 12/4/2025. Documentation of the support plan revisions was placed in each resident's record.
Effective immediately all resident support plans will be promptly revised by DOW or designee when there is a change in a resident's change of condition, not solely at annual review.
Effective 12/4/2025 the Administrator or DOW will audit 10 resident records monthly for a period of three months to identify any changes that require support plan updates. This review will continue through April 1, 2026.(All

234d Support Plan Revision (continued)

audits and in services will be maintained and ready for the Department to review upon request).

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented ([redacted] - 05/28/2026)

251b - Record Entries Legible

19. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident #1's medical evaluation dated [redacted] on medical diagnoses addendum bullet 10.

Plan of Correction ***Accept ([redacted] - 02/05/2026)***

Resident #1 is no longer living at the community. The DME dated [redacted] was noted to indicate that the use of correction fluid was found during the annual survey of November 25, 2025.
All staff responsible for resident documentation were in serviced by the DOW on 12/4/2025 on proper documentation standards, including correct methods for correcting errors (single line through error, initialed, dated, and explained as needed). (See attached in service).
The Administrator or DOW will audit 10 resident records monthly for a period of three months to ensure entries are permanent, legible, dated and signed to begin 1/1/2026 and end 4/1/2026.(All audits and in services will be maintained and ready for the Department to review upon request).

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented ([redacted] - 05/28/2026)