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

April 2, 2026

[REDACTED], REGIONAL OPS
227 EVERGREEN ROAD OPERATIONS LLC
227 EVERGREEN ROAD
POTTSTOWN, PA, 19464

RE: SANATOGA COURT
227 EVERGREEN ROAD
POTTSTOWN, PA, 19464
LICENSE/COC#: 13614

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/01/2025, 12/03/2025 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: *SANATOGA COURT* **License #**: *13614* **License Expiration**: *06/20/2026*

Address: *227 EVERGREEN ROAD, POTTSTOWN, PA 19464*

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

Administrator

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

Legal Entity

Name: *227 EVERGREEN ROAD OPERATIONS LLC*

Address: *227 EVERGREEN ROAD, POTTSTOWN, PA, 19464*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/10/1998* **Issued By**: *CWOPA*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *12/03/2025*

Inspection Dates and Department Representative

12/01/2025 - On-Site: [redacted]

12/03/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *38*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Homestead* **Capacity**: *28* **Residents Served**: *5*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *38*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *16* **Have Physical Disability**: *0*

Inspections / Reviews

12/01/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/26/2025*

Inspections / Reviews *(continued)*

01/02/2026 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/29/2026*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *01/09/2026*

01/08/2026 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/29/2026*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *01/29/2026*

04/02/2026 - Document Submission

Submitted By: [redacted]
Date Submitted: *01/29/2026*
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 7/17/2025, Resident 1 reported that $226 in cash was missing from their room. This allegation of theft was not reported to the local Area Agency on Aging.

Repeat Violation Date: 11/25/24 et al.

Plan of Correction ***Accept (█ - 01/08/2026)***

Effective December 2, 2025, any staff person suspected of abuse, neglect, exploitation, or mistreatment of a resident will be immediately removed from all direct resident contact pending the outcome of the investigation, in accordance with the Older Adult Protective Services Act and applicable PA DHS regulations regarding staff restrictions.

The alleged incident will be reported immediately on the date of discovery to the appropriate authorities, including the local Area Agency on Aging and PA DHS, as required. The staff member will not be permitted to return to resident care duties until the investigation is completed and a determination is made that it is safe and appropriate to do so.
Documentation of the allegation, reporting, immediate protective actions taken, staff restrictions imposed, investigation findings, and final determinations will be completed within 24 hours of the incident and maintained in the resident's record and the staff member's personnel file in accordance with regulatory record-retention requirements.

The Administrator or designee will be responsible for oversight and ongoing monitoring. A review of compliance with abuse reporting, staff restriction procedures, and documentation practices will be conducted by December 16, 2025, and monthly thereafter to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 02/11/2026)

17 - Record Confidentiality

2. Requirements

2600.

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

Description of Violation

On 12/1/2025, at 9:25AM, multiple binders containing Resident Assessment and Support Plan (RASP) and other resident care records were found in an unlocked cabinet in the unlocked laundry room.

17 - Record Confidentiality (continued)

On 12/1/2025, at 11:00AM, Staff member A was observed leaving a Medication Administration Record (MAR) binder on top of the medication cart that was remained in the hallway, unattended, while administering medications to Resident 2 in their apartment.

Repeat Violation Date: 11/25/24 et al.

Plan of Correction ***Accept (█ - 01/08/2026)***

On December 1, 2025, upon discovery, all resident records—including MAR binders, RASP documentation, assessments, and all supporting records—were immediately removed from the unlocked laundry room and secured in a locked cabinet located in a staff-only restricted area to ensure resident confidentiality and compliance with PA DHS record-security requirements.

On December 1, 2025, staff present at the time of discovery were re-educated immediately on confidentiality requirements, including the prohibition against leaving resident records unattended or accessible in public or unsecured areas.

By December 16, 2025, all staff will receive reinforcement education regarding the proper storage, handling, and security of resident records. Education will be documented and maintained in staff training files.

The Administrator or designee will conduct weekly audits for 30 days beginning December 2, 2025, followed by monthly audits thereafter, to ensure resident records are stored securely at all times. Any identified issues will be addressed immediately through corrective action and re-education.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 04/02/2026)

26b - Quality Management Plan Content

3. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

Description of Violation

According to the home's quality management policy, the home is to meet quarterly for periodic review. The home has not held a meeting since June 2025.

Repeat Violation Date: 11/25/24 et al.

Plan of Correction ***Accept (█ - 01/08/2026)***

On December 16, 2025, the Quality Management (QM) Plan was revised to include periodic review and evaluation of: reportable incident and condition reporting procedures; complaint procedures; staff training; licensing violations and Plans of Correction; and resident and/or family council input, when applicable. Quality Management meetings will begin on December 22nd 2025, and will be held quarterly thereafter. During each meeting, the QM committee

26b - Quality Management Plan Content (continued)

will review all required components, identify trends, implement corrective actions as needed, and evaluate the effectiveness of prior interventions.

Meeting minutes, attendance records, reviewed data, and follow-up actions will be documented and maintained in the Quality Management file to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 02/11/2026)

63a - First Aid/CPR Training

4. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 11/18/25, from 11pm to 7am, 38 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid/CPR.

On 11/22/25, from 3pm to 7am, 38 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid/CPR.

Plan of Correction ***Accept (█ - 01/08/2026)***

Effective December 1 2025, upon identification of the deficiency, the facility immediately reviewed and revised staffing schedules to ensure that at least one staff person per 50 residents with current First Aid, CPR, and obstructed airway certification is present in the home at all times, including overnight shifts, weekends, and holidays.

Staffing assignments were adjusted immediately to provide certified coverage on all shifts. A verification audit of current certifications was completed for all staff assigned to provide coverage, and certification records are maintained in personnel files.

Preventive Measures
Staff members who are not CNA-certified and do not currently hold CPR certification were scheduled for CPR and First Aid training, with classes initiated on December 2, 2025, and completion expected by December 16, 2025.

Going forward, the facility will:

Maintain a CPR/First Aid certification tracking log

Review certification status monthly

Ensure scheduling practices require certified staff coverage prior to finalizing schedules

Monitoring and Oversight

The Administrator or designee will conduct weekly schedule reviews for 30 days beginning November 23, 2025, followed by monthly reviews thereafter, to ensure compliance with staffing and certification requirements. Any identified gaps will be corrected immediately.

63a - First Aid/CPR Training (continued)

Person(s) Responsible
Administrator / Designee

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 04/02/2026)

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

On 12/2/25 at 1pm, Resident 3 had a bedside mobility device with no cover present. The device had openings of 13 inches wide from bar to bar and 17 inches high from the top of the bar to the bed. The size of this opening requires a secure cover to reduce the risk to the resident.

Repeat Violation Date: 11/25/24 et al.

Plan of Correction ***Accept (█ - 01/08/2026)***

Upon identification of the deficiency, all resident mobility and assistive devices were inspected to ensure they were clean, safe, properly fitted, and free of hazards. Any unsafe or damaged equipment was removed from service and corrected immediately through repair or replacement.

Systemic Correction: The Physical Therapy Department or designee will conduct monthly audits of wheelchairs, walkers, prosthetic devices, bedside mobility devices, and other resident apparatus to ensure:
• Devices are clean and free of visible debris
• Equipment is in good working order and free of hazards
• Secure covers are present when required
• Devices are properly fitted and appropriate for resident use

Staff Education: All direct care staff were re-educated on the requirement to routinely observe resident equipment for cleanliness and safety and to promptly report any concerns to management or Physical Therapy.

Immediate correction completed: 12/02/2025

Staff re-education completed: 12/18/2025

Monthly audit process implemented: 12/15/2026

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 04/02/2026)

82c - Locking Poisonous Materials

6. Requirements

82c - Locking Poisonous Materials *(continued)*

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 12/1/25 at 9:24am, a bottle of MultiRapid blue cleaning spray, with a manufacturer's label indicating "hazardous to humans-contact poison control", was unlocked, unattended, and accessible to residents under the sink in the Homestead kitchenette.

Plan of Correction ***Accept (█ - 01/08/2026)***

pon identification of the deficiency, all poisonous materials, including cleaning supplies, chemicals, and maintenance products, were immediately secured in locked cabinets or rooms and made inaccessible to residents.

Systemic Correction: The facility will ensure that all poisonous materials are stored in locked and clearly designated areas at all times unless it is verified that all residents living in the home are able to safely use or avoid such materials.

Immediate correction completed: 12/01/2025

Staff re-education completed: 12/18/2025

Monthly audit process implemented: 12/18/25

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 04/02/2026)

85a - Sanitary Conditions

7. Requirements

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

Description of Violation

On 12/1/25 at 9:25am, there was a large dried sticky puddle of pink liquid on the bottom surface of the refrigerator under the bottom drawer.

Plan of Correction ***Accept (█ - 01/08/2026)***

Upon discovery, the refrigerator was removed from service immediately. The affected area was cleaned and sanitized, and all food items were inspected. Any food items that were questionable or potentially compromised were discarded.

Corrective Action: Due to the condition of the unit and the inability to ensure proper sanitation, the refrigerator was fully replaced with a new unit on 12/16/2025.

Systemic Correction: Supervisory staff will conduct random audits of kitchen equipment to ensure all equipment remains clean, sanitary, and in good repair.

85a - Sanitary Conditions (continued)

Monitoring: Audit findings will be documented and reviewed by administration. Any deficiencies identified will be corrected immediately to ensure ongoing compliance with § 2600.87(a).
Immediate removal, cleaning, and food inspection completed: 12/01/2025

Refrigerator replacement completed: 12/16/2025

Ongoing audit process implemented: 12/22/2025

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 02/11/2026)

85e - Trash Outside Home

8. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 12/1/25 at approximately 9:30am, a dumpster outside of the main kitchen was observed having a large piece of frayed, white plastic hanging out of the side.
On 12/1/25 at approximately 9:35am, there was an accumulation of trash and debris that was scattered outside on the grass by the stair tower 3 exit.

Plan of Correction ***Accept (█ - 01/08/2026)***

on discovery, housekeeping was notified immediately. The frayed plastic material was removed from the dumpster, and the dumpster area was inspected to ensure no additional hazards or debris were present.
Housekeeping staff were re-educated on proper dumpster use and the importance of ensuring all waste is fully contained within dumpsters. A daily exterior waste area check was added to housekeeping responsibilities.
Housekeeping supervisors will ensure dumpsters are visually inspected during each shift. Immediate correction completed: 01/06/2026

Staff re-education completed: 12/18/2025

Daily monitoring initiated: 12/18/2025

30-day monitoring period completed: 01/18/2025

Staff Education: Re-education was provided by the Environmental Services/Housekeeping Supervisor and included proper waste containment, hazard identification, and prompt reporting of concerns.

Monitoring: Housekeeping supervisors will monitor dumpster conditions daily. Findings will be documented and any concerns will be addressed immediately. Monitoring will occur for a minimum of 30 days to ensure sustained compliance with § 2600.87(a).

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 04/02/2026)

88a - Surfaces

9. 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 12/1/25 at approximately 9:40am, ceiling tiles were missing in two separate locations in the home, above room 248 and above the 2nd floor middle elevator.

On 12/1/25 at approximately 9:30am, two water stained ceiling tiles were found located above room 224, one of which appearing to have a green/black moldy substance.

On 12/1/25 at approximately 10:10am, there was a a very large accumulation of water pooled on the floor of the entire boiler room area.

Plan of Correction ***Accept (- 01/08/2026)***

Maintenance was notified immediately. Replacement ceiling tiles were installed in both affected locations on 12/01/2025. Surrounding areas were inspected to ensure no additional ceiling tiles were missing or damaged.

Corrective Action: Maintenance investigated the source of the water intrusion. The identified leak was fully repaired on 12/03/2025. The boiler room was re-inspected following repair to confirm no further water accumulation or damage was present.

Systemic Changes to Prevent Recurrence: Environmental rounds were reinforced to include inspection of ceiling integrity. Ceiling conditions were added to routine building inspections. Maintenance staff were re-educated on the importance of promptly reporting and correcting missing or damaged ceiling tiles.

Staff Education: Re-education was provided by the Maintenance Supervisor and included identification of ceiling damage, reporting procedures, and timely corrective action.

Monitoring: Maintenance will monitor the area above Room 224 during weekly rounds, with additional inspections conducted following any heavy rain or plumbing issues. Monitoring will continue for 30 days to ensure sustained compliance. Findings will be documented and addressed immediately if concerns are identified.

Ceiling tile replacement completed: 12/01/2025

Leak repair completed: 12/03/2025

Staff re-education completed: 12/10/2025

Monitoring/rounds initiated: 12/11/2025

30-day monitoring period completed: 01/09/2026

Licensee's Overall Completion Date: 12/26/2025

Update submitted: 01/02/2026

88a - Surfaces *(continued)*

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 02/11/2026)

95 - Furniture and Equipment

10. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 12/1/25 at approximately 10:10am, there was an active leak coming from the middle blue pipes which was spraying a stream of water directly on the floor of the boiler room.

On 12/1/25 at approximately 9:45am, a keypad located in the courtyard outside of the SDCU TV room was found dry rotted and falling apart, making the keypad completely inoperable.

Plan of Correction ***Accept (█ - 01/08/2026)***

Maintenance was notified immediately upon discovery of both conditions. The boiler room area was secured, and the water source was investigated. The damaged keypad was assessed and secured to prevent use until repair could be completed.

Corrective Action: Maintenance investigated the source of the boiler room leak, and the identified issue was fully repaired on 12/03/2025. The boiler room was re-inspected following repair to confirm no further water intrusion or accumulation was present. The dry-rotted and inoperable keypad was replaced with a new, fully operational unit on 12/02/2025, restoring secure access control to the courtyard area.

Training / Staff Education: Maintenance staff received re-education on 12/10/2025 regarding prompt identification, reporting, and correction of environmental hazards, including plumbing leaks and access-control equipment failures. Training topics included environmental safety, emergency reporting procedures, and documentation requirements. Training was provided by the Maintenance Supervisor.

Systemic Changes to Prevent Recurrence: Environmental rounds were reinforced to include inspection of plumbing systems, boiler room conditions, and access-control devices. These elements were added to routine building inspection checklists.

Monitoring / Auditing for Ongoing Compliance: Maintenance will conduct weekly environmental rounds beginning 12/11/2025, which will include inspection of the boiler room piping and SDCU courtyard access equipment. Additional inspections will occur following heavy rain, plumbing work, or mechanical issues. Monitoring will continue for a minimum of 30 days. Findings will be documented, reviewed by administration, and any concerns corrected immediately.

Immediate notification and securing completed: 12/01/2025

Keypad replacement completed: 12/02/2025

Leak repair completed: 12/03/2025

95 - Furniture and Equipment (continued)

Staff re-education completed: 12/10/2025

Monitoring initiated: 12/11/2025

30-day monitoring period completed: 01/09/2026

Licensee's Proposed Overall Completion Date: *01/06/2026*

Implemented (█ - 02/11/2026)

103e - Left Overs

11. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 12/1/25 at approximately 9:30am the following was observed in the Homestead Kitchenette area:

- *an unlabeled, undated bowl of left-over peanut butter found in a cabinet above/next to the sink.*
- *two unlabeled, undated plastic containers of unknown food in the refrigerator*
- *an opened, unlabeled bottle of water on the refrigerator door*
- *an unlabeled, undated disposable half-full coffee cup on the bottom shelf of the refrigerator*

Plan of Correction ***Accept (█ - 01/08/2026)***

Effective December 2, 2025, all dietary and direct care staff were re-educated on food safety requirements, specifically that food served to and returned from an individual's plate shall not be re-served or used in the preparation of other dishes, and that all leftover food must be properly labeled and dated prior to storage. Re-education was provided by the Dietary Manager and documented in staff training records.

All existing leftover food items in refrigerators and freezers were reviewed on December 2, 2025, and any items not properly labeled or dated were discarded immediately.
Beginning December 3, 2025, the Dietary Manager or designee will conduct:

Daily visual inspections of food preparation areas and refrigerators during meal service

Weekly documented audits of refrigerators and freezers to verify proper labeling, dating, and disposal practices

Audits will be documented on a Food Safety Monitoring Log.

After 30 days of compliance, monitoring will transition to monthly audits, beginning January 3, 2026, and will continue ongoing.

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (█ - 04/02/2026)

103f - Refrigerator/Freezer Temps

12. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 12/1/25 at 9:27am the temperature in the refrigerator in the Homestead kitchenette was 48 degrees Fahrenheit.

Plan of Correction ***Accept (- 01/08/2026)***

Beginning December 2, 2025, the Dietary Manager or designee will conduct and document daily temperature checks of all refrigerators and freezers using appliance thermometers. Temperatures will be recorded on a Temperature Monitoring Log.

The Administrator or designee will review temperature logs weekly for 30 days, beginning December 2, 2025, to ensure compliance and identify trends.

After January 2, 2026, monitoring will transition to monthly audits, conducted by the Administrator or designee, and will continue ongoing to ensure sustained compliance.

Any temperatures found outside acceptable ranges will be addressed immediately, with corrective action and re-education provided as necessary.

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (- 02/11/2026)

103i - Outdated Food

13. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 12/1/25 at approximately 9:30am the following was observed in the Homestead Kitchenette area:

- *an unlabeled, undated container of brown sugar in an upper cabinet next to the sink*
- *an unlabeled, undated, metal container with cut peaches in syrup in the refrigerator*
- *an unlabeled, undated container or red juice in the refrigerator*

Repeat Violation Date: 11/25/24 et al.

Plan of Correction ***Accept (- 01/08/2026)***

On December 1, 2025, all unlabeled and undated food items were discarded immediately.

On December 15, 2025, the refrigerator in the Homestead Kitchenette was replaced with a new unit. All food items placed in the new refrigerator were verified to be properly labeled and dated at the time of storage.

Training Conducted to Ensure Ongoing Compliance

On December 18, 2025, all dietary staff and any staff with access to food storage areas received mandatory re-education on:

Prohibition against use of outdated, spoiled, or improperly stored food

103i - Outdated Food (continued)

Proper labeling and dating of all food items upon opening or preparation

Immediate disposal of unlabeled or expired food

Infection control and food safety requirements per § 2600.103(i)

Training was provided by the Dietary Manager, with oversight by the Administrator, and was documented through sign-in sheets and maintained in staff training files.

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (█ - 04/02/2026)

105g - Lint Removal and Duct Cleaning

14. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer’s instructions.

Description of Violation

On 12/1/25, there was an approximate 1/4 inch accumulation of lint in the lint trap of each the Homestead dryers and the 1st and 2nd floor dryers in the resident laundry rooms. There were no clothes in any of the dryers at the time.

Plan of Correction ***Accept (█ - 01/08/2026)***

Corrective Action Taken
On 12/1/25, all lint was immediately removed from all dryer lint traps, and all dryers were inspected and confirmed free of lint prior to continued use.

Prevention and Monitoring: Daily Cleaning: Effective 12/2/25, housekeeping staff clean dryer lint traps after each use and daily, including when dryers are not in active use.

Weekly Inspections: Weekly secondary inspections began 12/6/25 and are conducted by Maintenance to verify lint traps and dryer drums are free of lint.

Cleaning Log: A Dryer Lint Trap Cleaning Log was implemented on 12/2/25 for all laundry areas. Staff initial and date the log after each cleaning. Logs are reviewed weekly by Maintenance and monthly by Administration.

Training
On 12/18/2025 housekeeping and maintenance staff were trained on lint removal requirements, fire safety risks, and log documentation. Training was provided by the Maintenance Supervisor and documented in staff training records.

Responsible Persons
Housekeeping Staff, Maintenance Staff, Administrator

Date of Full Compliance
12/26/25

105g - Lint Removal and Duct Cleaning *(continued)*

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (- 04/02/2026)

107d - Procedure Emergency Management Agency Submission

15. Requirements

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

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since 08/22/2024.

Plan of Correction ***Accept (- 01/08/2026)***

Plan of Correction
On January 3, 2026, the home's written emergency procedures were reviewed and updated by the Maintenance Helper and Regional Director.

On January 5, 2026, the updated emergency procedures were submitted to the local emergency management agency for review and acknowledgment.

The Administrator will ensure the emergency procedures are reviewed, updated, and submitted annually, with documentation maintained in the Emergency Management binder.

Date of Full Compliance
January 5, 2026

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (- 02/11/2026)

125a - Combustible Storage

16. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

In the elevator closet on the first floor, a stack of fabric elevator wall covers were stored next to the electrical unit of the elevator controls.

Plan of Correction ***Accept (- 01/08/2026)***

Corrective Action Taken
On December 5, 2025, the Maintenance Supervisor removed the fabric elevator wall covers from the elevator closet and relocated them to a housekeeping storage closet, away from all heat and electrical sources.

Training
On December 6, 2025, maintenance and housekeeping staff were trained on:

125a - Combustible Storage (continued)

Proper storage of combustible and flammable materials

Prohibition against storing materials near heat sources, hot water heaters, or electrical equipment

Training was provided by the Maintenance Supervisor and documented in staff training records.

Monitoring and Ongoing Compliance
Beginning December 6, 2025, the Maintenance Supervisor will conduct:

Weekly inspections for 30 days of elevator closets, mechanical rooms, and storage areas

Monthly inspections thereafter, ongoing

Findings will be documented, and any noncompliance will be corrected immediately.

Persons Responsible
Maintenance Supervisor
Administrator (oversight)

Date of Full Compliance
December 23, 2025

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (- 04/02/2026)

141a - Medical Evaluation

17. 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.

Description of Violation

Resident 4 was admitted on and had a medical evaluation completed , which was more than 60 days prior to admission.

Plan of Correction ***Accept (- 01/08/2026)***

Plan of Correction
A Medical Evaluation Checklist was implemented on December 2, 2025, and is now required to be completed and verified prior to admission or within 30 days after admission, as applicable.

On December 2, 2025, nursing and administrative staff were trained on:

Medical evaluation timing requirements

Use of the Medical Evaluation Checklist

141a - Medical Evaluation (continued)

Verification of required medical documentation

Training was provided by the Administrator and documented in staff training records.

Audits began on December 3, 2025. The Administrator or designee will:

Conduct weekly audits for 30 days of all new admissions

Conduct monthly audits thereafter, ongoing

Any deficiencies identified will be corrected immediately.

Date of Full Compliance
December 26, 2025

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented ([redacted] - 04/02/2026)

141a 1-10 Medical Evaluation Information

18. 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.

Description of Violation

Resident 5 had a medical evaluation dated [redacted] which did not include medical, physical, and mental diagnosis as well as their medication addendum.

Plan of Correction ***Accept ([redacted] - 01/08/2026)***

Plan of Correction
A Medical Evaluation Tracking Checklist and Master Log were implemented on December 2, 2025, to ensure all required components of the medical evaluation are completed within required timeframes.

On December 2, 2025, nursing and administrative staff were trained on:

141a 1-10 Medical Evaluation Information (continued)

Required components of the medical evaluation per § 2600.141(a)

Use of the tracking checklist and master log

Verification of medical, mental, physical diagnoses and medication addendum

Training was provided by the Administrator and documented in staff training records.

Audits began on December 3, 2025. The Administrator or designee will:

Conduct monthly audits of the medical evaluation master log

Utilize PCC alerts 30 days prior to due dates to ensure timely completion

Any deficiencies identified will be corrected immediately.

Date of Full Compliance
December 26, 2025

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (- 04/02/2026)

141b1 - Annual Medical Evaluation

19. Requirements

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

Description of Violation

Resident 4's most recent medical evaluation was completed on

Plan of Correction ***Accept (- 01/08/2026)***

Plan of Correction
A Medical Evaluation Tracking Checklist and Master Log were implemented on December 2, 2025, to monitor completion and due dates for all annual medical evaluations.

Audits began on December 3, 2025. The Administrator or designee will conduct monthly audits of the medical evaluation master log and utilize PCC alerts set 30 days prior to due dates to ensure timely completion.

Any identified deficiencies will be corrected immediately.

Date of Full Compliance
December 26, 2025

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (- 04/02/2026)

162c - Menus Posted

20. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 12/1/25, the home's menu for the week of 10/19 through 11/13 was posted. However, there was no menu for the current week or following week.

Plan of Correction ***Accept (- 01/02/2026)***

Menus will be rotated in a timely manner posting current week and next week.
The dietary director will monitor the weekly posting. This will be completed weekly and completion date was 12/5/2025

Licensee's Proposed Overall Completion Date: *12/26/2025*

Implemented (- 02/11/2026)

182c - Medication Administration

21. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

Description of Violation

Resident 2 is prescribed Midodrine 5mg 1 tablet by mouth three times daily for systolic blood pressure greater than 120.
On 12/1/25 at 11:02AM, Staff Member A took Resident 2's blood pressure reading and signed the MAR as administered prior to actually administering the medication. After signing the MAR, Staff Member A proceeded apply hand sanitizer and administered the medication to Resident 2.

Plan of Correction ***Accept (- 01/08/2026)***

Corrective Action Taken
On 12/1/25, Resident 2 was assessed following the documentation error. The medication was administered as prescribed, and no adverse effects were noted. The MAR entry was reviewed and clarified.

Training
On December 2, 2025, all medication administration staff received re-education on:

Administering medication prior to MAR documentation

Completing required vital signs before administration when ordered

Real-time, accurate MAR documentation requirements

Training was provided by the Director of Nursing / Designee and documented in staff training records.

Monitoring and Ongoing Compliance
Beginning December 3, 2025, the Director of Nursing or designee will:

182c - Medication Administration (continued)

Conduct weekly MAR audits for 30 days

Conduct monthly MAR audits thereafter, ongoing

Any discrepancies will result in immediate corrective action and re-education.

Date of Full Compliance
December 26, 2025

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (█ - 04/02/2026)

183e - Storing Medications

22. 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 12/3/25, a Novolog insulin pen belonging to Resident 1, was observed and did not have an open date on it. Per manufacturer's instructions, the unused portion of medication must be discarded 28 days after opening.

Repeat Violation Date: 11/25/24 et al.

Plan of Correction ***Accept (█ - 01/08/2026)***

Corrective Action Taken
On 12/3/25, the undated Novolog insulin pen was removed and properly discarded. A new insulin pen was obtained, labeled and dated upon opening, and stored in accordance with manufacturer's instructions.

Training
On December 4, 2025, all staff responsible for medication administration and medication cart management were re-educated on:

Dating all insulin pens and multi-dose injectable medications immediately upon opening

Discarding medications without an open date

Manufacturer storage and discard requirements

Training was provided by the Director of Nursing and documented in staff training records.

Monitoring and Ongoing Compliance
Beginning December 5, 2025, the Director of Nursing or designee will:

Conduct weekly medication cart audits for 30 days to verify proper labeling, dating, and storage

183e - Storing Medications (continued)

Conduct monthly audits thereafter, ongoing

Audit results will be documented. Any noncompliance will result in immediate corrective action and re-education.

Date of Full Compliance
December 26, 2025

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (█ - 04/02/2026)

224a - Preadmission Screen Form

23. 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 6 was admitted to the home on █ however, the resident did not have a preadmission screening.

Plan of Correction ***Accept (█ - 01/08/2026)***

Plan of Correction
On December 2, 2025, a facility-wide audit of resident charts was completed to verify the presence of a preadmission screening for all current residents. Any missing documentation was addressed immediately.

On December 2, 2025, admissions and administrative staff received re-education on preadmission screening requirements, including the requirement that admissions will not be finalized without a completed preadmission screening dated within 30 days prior to admission. Training was provided by the Administrator and documented in staff training records.

Effective December 3, 2025, the Administrator or designee will review and approve all admissions prior to acceptance to ensure a completed preadmission screening is present.

Date of Full Compliance
December 26, 2025

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (█ - 04/02/2026)

225c - Additional Assessment

24. 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.

225c - Additional Assessment *(continued)*

Description of Violation

Resident 1's most recent assessment was completed on

Plan of Correction ***Accept (- 01/08/2026)***

A Centralized Assessment Tracking Log was implemented on December 2, 2025, to track due dates for annual assessments and assessments required due to significant change in condition or Department request.

On December 2, 2025, nursing and administrative staff were re-educated on:

Annual and change-in-condition assessment requirements

Use of the assessment tracking log

Timely completion and documentation of additional assessments

Training was provided by the Administrator and documented in staff training records.

Audits began on December 3, 2025. The Administrator or designee will conduct monthly reviews of the assessment tracking log to ensure assessments are completed and updated as required. Any deficiencies identified will be corrected immediately.

Date of Full Compliance
December 26, 2025

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (- 04/02/2026)

227h - Support Plan Refuse Sign

25. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident 1 participated in the development of support plan on . The resident chose not to sign the support plan. The home did not make a notation regarding the resident's refusal to sign.

Plan of Correction ***Accept (- 01/08/2026)***

On December 2, 2025, an initial audit of all resident support plans was completed to verify that each plan contains either a resident/designated person signature or documented notation of inability or refusal to sign. The audit was conducted by the Administrator. Any missing documentation was corrected immediately.

On December 2, 2025, nursing and administrative staff were re-educated on support plan requirements, including the requirement to document a resident's inability or refusal to sign. Training was provided by the Administrator and documented in staff training records.

Beginning December 3, 2025, the Administrator or designee will:

227h - Support Plan Refuse Sign (continued)

Review all newly completed or revised support plans prior to finalization to ensure proper signature or refusal documentation

Conduct monthly audits of support plans to ensure ongoing compliance

Any deficiencies identified will be corrected immediately.

Date of Full Compliance
December 26, 2025

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (█ - 04/02/2026)

233d - Electronic/Magnetic System

26. Requirements

2600.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

On 12/1/25, in the Homestead courtyard, there was a gate equipped with a magnetic lock, however the lock was not operational and the gate door was able to be pushed open. There was no other locking mechanism on the gate to secure the courtyard.

Plan of Correction ***Accept (█ - 01/08/2026)***

Corrective Action Taken
On December 16, 2025, an outside vendor repaired and restored the magnetic locking mechanism on the Homestead courtyard gate. The gate was tested and confirmed to be fully operational and secure.

Monitoring and Ongoing Compliance
Beginning December 17, 2025, the Maintenance Supervisor will:

Conduct daily visual checks of the courtyard gate lock to verify proper operation

Conduct weekly documented functional tests of the magnetic locking system

Beginning January 16, 2026, monitoring will transition to monthly documented inspections, conducted by the Maintenance Supervisor and reviewed by the Administrator.

Any malfunction identified will be reported immediately and corrected without delay.

Date of Full Compliance
December 26, 2025

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented (█ - 04/02/2026)