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

April 3, 2026

JUNIPER VILLAGE AT BENSALEM OPERATIONS LLC

RE: JUNIPER VILLAGE AT BUCKS COUNTY SENIOR LIVING
3200 BENSALEM BOULEVARD
BENSALEM, PA, 19020
LICENSE/COC#: 14246

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/02/2025, 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *JUNIPER VILLAGE AT BUCKS COUNTY SENIOR LIVING* **License #**: *14246* **License Expiration**: *04/18/2026*

Address: *3200 BENSALEM BOULEVARD, BENSALEM, PA 19020*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *JUNIPER VILLAGE AT BENSALEM OPERATIONS LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *04/28/1993* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *69* **Waking Staff**: *52*

Inspection Information

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

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

Inspection Dates and Department Representative

12/02/2025 On Site:

12/03/2025 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *42*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care Unit* **Capacity**: *21* **Residents Served**: *16*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *42*

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

Have Mobility Need: *27* **Have Physical Disability**: *0*

Inspections / Reviews

12/02/2025 - Full

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *12/26/2025*

Inspections / Reviews *(continued)*

12/26/2025 POC Submission

Submitted By: [redacted]
Date Submitted: *01/16/2026*
Reviewer: [redacted]
Follow Up Type: *POC Submission* **Follow Up Date**: *12/31/2025*

01/05/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *01/16/2026*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date**: *01/22/2026*

04/03/2026 Document Submission

Submitted By: [redacted]
Date Submitted: *01/16/2026*
Reviewer: [redacted]
Follow Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On [redacted] a copy of the home's current license inspection summary issued by the Department and a copy of this chapter were not posted in a conspicuous and public place in the home's personal care unit.

Plan of Correction ***Accept [redacted] - 12/26/2025)***

A copy of the home's current licenses inspection summary was present at the time of survey, 12/2/25, but was placed in a location that was not visible immediately. Home's current licenses inspection summary binder was placed back in original spot during survey, 12/2/25, by administrator. Administrator/designee will audit both floors of personal care to ensure the home's current inspection summary binder is placed in a conspicuous and public place for 3 weeks starting on 12/29, then monthly for 2 months until 100% compliance

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

Implemented [redacted] - 04/03/2026)

5a1 - DHS Access

2. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On [redacted], at 9:00 a.m., an agent of the Department requested access to the facility to complete a physical site inspection. Staff did not make themselves available to help the agent until 9:29 a.m.

Plan of Correction ***Accept ([redacted] - 12/26/2025)***

Upon identification of the deficient practice, leadership reviewed the circumstances surrounding the delay in staff availability. Staff were immediately reminded of the requirement to provide timely access and assistance to Department agents upon arrival for inspections or site visits. Designation of a primary and secondary leadership contact (Administrator/Director of Nursing) responsible for greeting and assisting Department agents at all times during business hours. Phone numbers will be posted at the Nurses Station. Wellness and leadership staff will be educated by 12/29/25, including the requirement to immediately notify leadership upon an agent's arrival. Monitoring will occur for 30 days, and thereafter as part of routine compliance oversight.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented ([redacted] - 04/03/2026)

28e - Death of a Resident

3. Requirements

2600.

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

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 passed away on . Resident s personal belongings were removed from room on however, the refund check was not issued until

Plan of Correction ***Accept - 12/26/2025)***

Deficient practice cannot be retroactively fixed. Administrator/designee will educate the business office manager by 12/26/25 on the proper timeframe for refund checks which is within 30 days of the room being cleared out. Administrator will conduct monthly audits for three months starting in the month of January to ensure that any resident that passed, there is a refund check released within 30 days of the room being cleared out.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented - 04/03/2026)

28f - Resident's Funds and 30-day Refund

4. Requirements

2600.

28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident was discharged on . The home did not issue a refund check until .

Plan of Correction ***Accept - 12/26/2025)***

Deficient practice cannot be retroactively fixed. Administrator/designee will educate the business office associate responsible for refunds by 12/26/25 on the proper timeframe for refund checks which is within 30 days of being discharged. Administrator will conduct monthly audits for three months starting in the month of January to ensure that any resident that discharged, there is a refund check released within 30 days of discharge.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented - 04/03/2026)

42s - Privacy

5. Requirements

2600.

42s Privacy *(continued)*

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On [redacted] video cameras were present at the entrances of the Memory and Personal Care units and in the hallways throughout the home. Cameras are recording at least 72 hours, according to staff member A, the administrator. There are home rules posted at the entrance to the Memory Care unit that stipulate that the home is monitored, but there is no indication on the notice that the video cameras are monitoring and recording. There are also no postings on the Personal Care unit entrances.

Plan of Correction ***Accept ([redacted] - 12/26/2025)***

Signage for the camera system was present during state survey, 12/2/25 and 12/3/25. Administrator will develop signage stating that the cameras throughout the home are monitoring and recording. Signage will be posted by 12/22/2025. Administrator/designee will audit weekly for 3 weeks and then monthly for 2 months to ensure the proper camera signage is posted and visible in memory care and personal caring starting the week of 12/22/25.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented ([redacted] - 04/03/2026)

54a - Direct Care Staff

6. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Staff person B does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept ([redacted] - 12/26/2025)***

Staff person B was taken off the schedule upon finding, 12/3/25, by Human Resource Director and Director of Wellness. Director of Human Resources will complete an initial audit of all of the resident associates to ensure they all have a high school diploma, GED, CNA, or waiver on file by 1/5/26 and immediately removed associates that do not have any of them on file until the proper documents are obtained. Director of Human Resources will audit any new hires weekly for 3 weeks and then monthly for 2 months until 100% compliance to ensure that all resident associates being onboarded have the proper documents in their files starting on 1/5/26.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented ([redacted] - 04/03/2026)

65g - Annual Training Content

7. Requirements

2600.

65g - Annual Training Content *(continued)*

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person C did not receive training during the training year 2024 in the following:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *Resident rights*
- *The Older Adult Protective Services Act.*
- *Falls and accident prevention.*
- *New population groups that are being served at the home that were not previously served.*

Plan of Correction ***Accept - 01/05/2026)***

No residents were harmed as a result of this deficient practice. A review of Staff Person C's training record was completed. It was confirmed that Staff Person C completed the following trainings during the 2024 training year: Preventing and Managing Accidents (03/16/2024); Cultural Competence and Healthcare (06/05/2024); Identifying Fall Risk in Assisted Living (10/14/2024); Workplace Emergencies and Natural Disasters: An Overview (08/17/2024); and Preventing, Recognizing, and Reporting Abuse (12/26/2024). Facility cannot retroactively train Staff person C for training due in 2024. Staff Person C will have all trainings up to date as of 12/31/25. If this does not occur, then Person C will be taken off the schedule until all educations for 2025 are completed. All current staff training records will be reviewed by Director of Human Resources to ensure compliance with the annual training requirements outlined in annual training plan. The facility will utilize an annual training plan to track and monitor completion of required trainings for all direct care staff. Fire safety training will be completed by a fire safety expert or by a staff person trained by a fire safety expert, with documentation maintained in each staff member's personnel file by end of first quarter (3/31/2026). The Administrator or designee will conduct quarterly audits of staff training records to ensure all required annual trainings are completed and documented according to the training plan. Any deficiencies identified will be corrected immediately.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented - 04/03/2026)

66b - Training Plan Content

8. 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.

66b - Training Plan Content *(continued)*

Description of Violation

The home's staff training plan does not include the name, position, and duties of each direct care staff person or the dates, times, and locations of the scheduled training for each staff person for the upcoming year.

Plan of Correction ***Accept - 12/26/2025)***

Deficient practice cannot be retroactively fixed for the year 2025. When working on the training plan for 2026, the administrator will add the name, position, and duties of each care staff person and the dates, times, and locations of the scheduled training for each staff person. Training plan will be completed by 1/5/2026 and placed in the survey ready binder by the administrator.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented 04/03/2026)

85d - Trash Receptacles

9. 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 at 11:40 a.m. there was a full, uncovered, unattended trash can in the main kitchen.

Plan of Correction ***Accept 12/26/2025)***

Lids were placed back on the trash cans by the dining staff upon discovery of this deficient practice. The Dining Director will train all scheduled dining staff by 1/5/26 on ensuring that all trash cans are fully covered if left unattended. Dining Director will conduct weekly audits for 3 weeks and then monthly audits for 2 months to ensure all trash cans in the main kitchen are fully covered when left unattended, audit will begin on 1/5/2026.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented (- 04/03/2026)

86b - Bathroom

10. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom in bedroom does not have an operable window or ventilation fan. The vent is inoperable, and there are no windows in the bathroom.

86b Bathroom (continued)

Plan of Correction ***Accept - 01/05/2026)***

Upon discovery of the inoperable vent, the Environmental Services Director investigated and ordered parts needed for repair. The vent that was inoperable will be fixed by Environmental Service Director/designee by 12/31/25 or as soon as parts arrive. Environmental Service Director will conduct weekly audits for 4 weeks testing 10 randomly selected vents in resident bathrooms to ensure they are all operable, audit will start the week of 12/29.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented 04/03/2026)

89b - Hot Water Temperature

11. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On at 10:45 a.m., the hot water temperature in bedroom measured 125.7, and bedroom measured 122.5 degrees Fahrenheit.

Plan of Correction ***Accept - 12/26/2025)***

Temperatures were adjusted by Environmental Service Director and below 120 prior to state surveyor exiting on 12/3. Environmental Service Director will conduct weekly audits for 4 weeks testing 10 randomly selected faucets in resident bathrooms to ensure they are testing at below 120, audit will start the week of 12/29.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented - 04/03/2026)

103g - Storing Food

12. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

There were 2 cheesecakes, 1 tray of fruit, 1 container of alfredo sauce, and 1 tray of cod in the main kitchen refrigerator that were opened and unsealed. There was also a large container of bread crumbs in the main kitchen that was opened and unsealed.

Plan of Correction ***Accept - 01/05/2026)***

Food was discarded by the dining staff upon discovery of this deficient practice. The Dining Director will train all

103g Storing Food (continued)

dining staff by 1/5/26 on the proper closing and sealing of containers in the main kitchen. Dining Director will conduct weekly audits for 3 weeks and then monthly audits for 2 months to ensure containers are closed and sealed properly, audit will begin on 1/5/2026.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented (- 04/03/2026)

103i - Outdated Food

13. Requirements

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

Description of Violation

There was an unlabeled, undated Italian cake, 1 tray of fruit, 1 container of alfredo sauce, 1 tray of cod, 1 tray of hamburgers, 1 bag of pretzels, and 1 small bag of egg rolls in the main kitchen refrigerator. There was also a large container of breadcrumbs in the main kitchen that was undated and unlabeled.

Plan of Correction ***Directed - 01/05/2026)***

Food was discarded by the dining staff upon discovery of this deficient practice. The Dining Director will train all dining staff who will have worked by 1/5/26 on the proper labeling, dating, and discarding of food in the main kitchen. Dining Director will conduct weekly audits for 3 weeks and then monthly audits for 2 months to ensure items are being label and dated properly, audit will begin on 1/5/2026.

Proposed Overall Completion Date: 01/16/2026

Directed step of POC (in addition to the above-mentioned steps):

Within 10 days of the receipt of the plan of correction: *All staff persons handling, preparing or storing food items shall be educated regarding the safe storage of food items including labeling and dating. Documentation of education shall be kept in accordance with 2600. 65i.*

Directed Completion Date: *01/16/2026*

Implemented 04/03/2026)

107d - Procedure Emergency Management Agency Submission

14. 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 reviewed, updated, and submitted annually to the local

107d Procedure Emergency Management Agency Submission (continued)

emergency management agency. There is no record of when it was the last time that the home submitted written emergency procedures to the emergency management agency.

Plan of Correction ***Accept ███ - 01/05/2026)***

Administrator provided documentation during survey that the emergency procedures were submitted in 2024 with a letter from the township fire department stating that they have an existing disaster plan that they will follow. 2025 submission has been submitted by the administrator to the township as of 12/2/2025 and 12/16/2025 with additional documentation. Administrator is awaiting response from the township with the official letter of acknowledgment. Once received the administrator will place in survey ready binder with previous years letter. 2026 plan will be submitted at the beginning of the year and letter will be placed in survey ready binder. Audit will be done weekly by Administrator or designee until letters received from township and placed in binder.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented ███ - 04/03/2026)

123b - Emergency Procedures Posted

15. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ███ - 01/05/2026)***

Emergency procedures will be posted on both floors by 12/31/25. Administrator will audit monthly for three months to ensure that the procedures are still posted in the glass cases that are located on both floors beginning in January.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented ███ - 04/03/2026)

141a - Medical Evaluation

16. 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

The medical evaluation for resident 3 does not include the dates of when the resident was evaluated and when the form was completed.

141a Medical Evaluation *(continued)*

Plan of Correction ***Accept - 01/05/2026)***

No resident was harmed by this deficient practice. Dates of evaluation and form completed were obtained and added to the medical evaluation. Director of Wellness will complete an education with all nursing staff who are responsible for medical evaluation forms by 1/5/2026 on dating all medical evaluation form for when they were completed. An initial audit will be conducted by the Director of Wellness reviewing all medical evaluations to ensure they have evaluation date and date of completion. Any evaluations not dated will be requested to be completed by 1/5/26. Director of Wellness/designee will audit any new medical evaluations that are completed weekly for 3 weeks then monthly for 2 weeks until 100% compliance to ensure that all forms are being dated for when the evaluation took place and when the form was completed starting on 1/5/2026.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented - 04/03/2026)

171b4 - Staff Training

17. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

Various staff persons, including staff person D, transported residents to appointments and activities. However, staff person D has not completed the initial new hire direct care staff person training, nor has any staff person who accompanied residents on trips.

Plan of Correction ***Accept - 01/05/2026)***

Deficient practice cannot be retroactively fixed. During the duration of drivers obtaining direct care staff person training, an associate that has direct care person training will accompany any residents that go on any outings. All drivers will obtain direct care staff person training by 1/20/26. Director of Human Resources will audit any new drivers that were hired weekly for 3 weeks and then monthly for 2 months until 100% compliance to ensure that they have direct care staff person training in their files starting on 1/5/26.

Licensee's Proposed Overall Completion Date: *01/20/2026*

Implemented - 04/03/2026)

185a - Implement Storage Procedures

18. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident is prescribed and as needed. On the medications were not available in the home.

Plan of Correction ***Accept (- 01/05/2026)***

Upon discovery of open orders for suppositories and as needed, Resident Primary Care Physician was notified and orders discontinued due to no need for these prescriptions. All nursing staff will be in serviced by the DOW on the correct protocol for obtaining, storing and disposing of medications from the medication cart when a discontinue order is received. Completion by 12/30/2025
Nursing staff on the 11p to 7a shift will conduct full medication cart audits 3x's weekly for the next 60 days to ensure that medications for all active orders are available for the resident's use. Nursing staff will report any discrepancies to the DOW for further review.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented - 04/03/2026)

190a - Completion Medication Course

19. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person B, who has not successfully completed the Department-approved medications administration course, administered medications to resident 4 to include the following:
On and at 8:00 a.m., .
On and at 8:00 a.m.,
On and at 8:00 a.m.,
On and at 8:00 a.m.,
On at 8:00 a.m., .
On at 8:00 a.m., .
On and at 8:00 a.m., .

Plan of Correction ***Accept 12/26/2025)***

Residents was did not experience any negative effects from this deficient practice. Staff person B was taken off the schedule upon finding, 12/3/25, by Human Resource Director and Director of Wellness. Staff person B was the only medication technician on staff, all other associates that administer medications are licensed practical nurses, so no initial audit will need to be conducted. Director of Human Resources will audit any new Medication Technician hires weekly for 3 weeks and then monthly for 2 months until 100% compliance to ensure that all medication technicians being onboarded have the proper documents in their files starting on 1/5/26.

190a - Completion Medication Course (continued)

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented - 04/03/2026)

221c - Post Activity Calendar

20. Requirements

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

The home does not have a current weekly activity calendar posted in a public and conspicuous place in the home.

Plan of Correction ***Accept - 12/26/2025)***

No resident was harmed as a result of this deficient practice. Catalyst Director posted the current weekly activity calendar during survey when the deficient practice was identified on 12/2/25. Administrator will educated Catalyst Director the requirement of a current weekly activity calendar be posted in a conspicuous and public place in the home by 12/26/25. Catalyst Director will conduct weekly audits for 3 weeks then monthly for 2 months to ensure that the current weekly activity calendar is posted in a conspicuous and public place starting on 12/29/25.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented - 04/03/2026)

225a - Assessment 15 Days

21. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident has a need for a bedside mobility device. The device is attached to the resident's bed frame. However, resident assessment, completed on , does not specify if the resident has a need for a bedside mobility device or if the resident was educated, and how this need will be met.

Plan of Correction ***Accept 12/26/2025)***

No resident was harmed as a result of this deficient practice. An addendum to Resident 's RASP will be completed by the Director of Wellness to include the use of a bedside mobility device by 12/26/2025. An initial audit of all residents utilizing bedside mobility devices will be completed by 1/5/2026 to ensure that use of the device is accurately reflected in each resident's RASP. For any RASP found to be missing this documentation, an addendum will be completed immediately by the Director of Wellness. The Director of Wellness will conduct weekly audits for 3 weeks, followed by monthly audits for 2 months, of all new orders for bedside mobility devices to ensure the required RASP addendum is completed, beginning 1/5/2026.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented (- 04/03/2026)

251b Record Entries Legible

22. 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

The medical evaluation for resident , dated and was not legible and has the completion dates overridden.

Plan of Correction ***Accept - 01/05/2026)***

No resident was harmed by this deficient practice. Violation cannot be retroactively corrected. Director of Wellness will complete an education with all nursing staff by 1/5/2026 on ensuring that the dates are legible and not overridden on resident records. Director of Wellness/designee will audit any new medical evaluations that are completed weekly for 3 weeks then monthly for 2 weeks to ensure that the dates are legible and not overridden until 100% compliance starting on 1/5/2026.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented - 04/03/2026)

251c Standardized Forms

23. Requirements

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

Description of Violation

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

Plan of Correction ***Accept (- 01/05/2026)***

No resident was harmed by this deficient practice. Violation cannot be retroactively corrected. Director of Wellness will complete an education with all nursing staff by 1/5/2026 on the proper medical evaluation form to use for initial, annual and significant change evaluations. Director of Wellness/designee will audit any new medical evaluations that are completed weekly for 3 weeks then monthly for 2 weeks until 100% compliance to ensure that the proper form is being used starting on 1/5/2026.

Licensee's Proposed Overall Completion Date: *01/16/2026*

Implemented - 04/03/2026)