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

January 20, 2026

[redacted]
BAPTIST HOMES SOCIETY
[redacted]

RE: PROVIDENCE POINT
200 ADAMS AVENUE
PITTSBURGH, PA, 15243
LICENSE/COC#: 44143

[redacted], [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/09/2025, 12/10/2025 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: *PROVIDENCE POINT* **License #**: *44143* **License Expiration**: *01/04/2026*

Address: *200 ADAMS AVENUE, PITTSBURGH, PA 15243*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *BAPTIST HOMES SOCIETY*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *10/04/2024* **Issued By**: *Township of Scott*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *110* **Waking Staff**: *83*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/10/2025*

Inspection Dates and Department Representative

12/09/2025 - On-Site: [redacted]

12/10/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served**: *66*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Cedar Boulevard & Maple* **Capacity**: *41* **Residents Served**: *32*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *66*

Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *44* **Have Physical Disability**: *0*

Inspections / Reviews

12/09/2025 Full

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

Inspections / Reviews *(continued)*

12/24/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/16/2026*

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

01/20/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/16/2026*

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

17 - Record Confidentiality

1. 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 [redacted] at approximately 10:30 a.m., there was a white binder labeled "Cedar Blvd. 24 hour shift report" on the front desk in the Cedar Boulevard secured dementia care unit (SDCU) that was found unlocked, unattended, and accessible with the shower schedule, room number and names of residents of the Cedar Boulevard SDCU to include:

- [redacted]

Plan of Correction ***Accept [redacted] 12/24/2025)***

Deficiency 2600.17 Record Confidentiality
Immediate Action – Identified Binder was immediately placed in locked nurses station by Healthcare Administrator and Director of EVS on 12/9/2025.

Education to be completed – All Aides, Med Techs and Nurses will be educated on the need to keep resident information private and confidential per 2600.17. Healthcare Administrator will conduct education and complete it by January 15th.

Audits to conducted – Resident common areas will be audited weekly X 4 weeks and then monthly X 2 months to ensure ongoing compliance.
Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator.

Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

25b - Contract Signatures

2. Requirements

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

25b Contract Signatures *(continued)*

Description of Violation

Resident [redacted] was admitted to the home's Cedar Boulevard secured dementia care unit on [redacted]. However, the resident home agreement, dated [redacted], was not signed or marked by resident [redacted]

Plan of Correction ***Accept[redacted] - 12/24/2025)***

Immediate Action Facility will secure resident [redacted]'s signature or mark on resident contract. Action will be completed by Admissions Director by 1/15/2026.

Education to be completed Admissions Director and Administrator will be educated on need for every resident to sign or place mark on resident contract per 2600.25b. Healthcare Administrator will conduct education and complete it by January 15th.

Healthcare Administrator will create new admission checklist to be completed for all new admissions to verify all required components are completed. Checklist will be created and put into place for all new admissions by 1/15/2026.

Audits to conducted All new admissions will be audited for resident signature or mark X 3 months.

Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented ([redacted] - 01/20/2026)

63a - First Aid/CPR Training

3. Requirements

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

Description of Violation

On [redacted] from 11:00 p.m. until 11:59 p.m., there were 60 residents in the personal care home with five direct care staff working and there was no direct care staff person in the home that was trained in first aid and certified in obstructed airway techniques and CPR.

On [redacted] from 12:00 a.m. until 6:30 a.m., there were 60 residents in the personal care home with five direct care staff working and there was no direct care staff person in the home that was trained in first aid and certified in obstructed airway techniques and CPR.

On [redacted] from 11:00 p.m. until 11:59 p.m., there were 60 residents in the personal care home and direct care staff person A was the only staff person in the home that was trained in first aid and certified in obstructed airway techniques and CPR.

On [redacted] from 12:00 a.m. until 6:30 a.m., there were 60 residents in the personal care home and direct care staff person A was the only staff person in the home that was trained in first aid and certified in obstructed airway

63a First Aid/CPR Training (continued)

techniques and CPR.

On [redacted] from 2:30 p.m. until 11:00 p.m., there were 61 residents in the personal care home with nine direct care staff working and there was no direct care staff person in the home that was trained in first aid and certified in obstructed airway techniques and CPR.

On [redacted] from 11:00 p.m. until 11:59 p.m., there were 61 residents in the personal care home and direct care staff person A was the only staff person in the home that was trained in first aid and certified in obstructed airway techniques and CPR.

On [redacted] from 12:00 a.m. until 6:30 a.m., there were 61 residents in the personal care home and direct care staff person A was the only staff person in the home that was trained in first aid and certified in obstructed airway techniques and CPR.

On [redacted] from 2:30 p.m. until 11:00 p.m., there were 61 residents in the personal care home and direct care staff person B was the only staff person in the home that was trained in first aid and certified in obstructed airway techniques and CPR.

On [redacted] from 11:00 p.m. until 11:59 p.m., there were 61 residents in the personal care home with five direct care staff working and there was no direct care staff person in the home that was trained in first aid and certified in obstructed airway techniques and CPR.

On [redacted] from 12:00 a.m. until 6:30 a.m., there were 61 residents in the personal care home with five direct care staff working and there was no direct care staff person in the home that was trained in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction ***Accept [redacted] - 12/24/2025)***

Immediate Action: Past occurrences of deficient practice unable to be corrected. Facility will plan first aid/CPR courses to ensure additional staff members are trained. Additional CPR and First Aid courses will be scheduled by PC Administrator and completed by 1/31/2026.

CPR/First Aid Classes have been scheduled for January 8th, 14th, 16th and 22nd for all nurses and aides who are not currently certified. First Aid and CPR certification is being made mandatory for all nurses and aides.

Education to be completed: Administrator, Scheduler, and HR staff will be educated on the first aid/cpr requirements listed in 2600.63a. Healthcare Administrator will conduct education and complete it by January 15th.

CPR/First Aid trained nurses from Skilled Nursing will remain available to assist on all shifts if a resident requires First Aid/CPR administration.

Audits to conducted Schedule will be audited once CPR/First aid classes are completed to ensure first aid/cpr requirements are met 2 days per week X 4 weeks and then 1 day per week X 2 months.

Audits will begin no later 1/31/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

63a - First Aid/CPR Training *(continued)*

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

Implemented [redacted] - 01/20/2026)

65a - FS Orientation 1st Day

4. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
5. The location and use of fire extinguishers.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person C, whose first day of work was [redacted] did not receive general orientation in general fire safety and emergency preparedness that included the following:

(5) The location and use of fire extinguishers.

(7) Telephone use and notification of emergency services.

Direct care staff person D, whose first day of work was [redacted], did not receive general orientation in general fire safety and emergency preparedness that included the following:

(5) The location and use of fire extinguishers.

(7) Telephone use and notification of emergency services.

Direct care staff person E, whose first day of work was [redacted], did not receive general orientation in general fire safety and emergency preparedness that included the following:

(5) The location and use of fire extinguishers.

(7) Telephone use and notification of emergency services.

Plan of Correction ***Accept [redacted] - 12/24/2025)***

Immediate Action – Direct Care persons C,D,E will receive general orientation training on general fire safety and emergency preparedness that include the location of fire extinguishers and telephone use and notification of emergency services. Action will be completed by HR Director and will be completed by 1/15/2026

Education to be completed – HR employees will be educated on general orientation requirements for new employees as listed in 2600.65a. Healthcare Administrator will conduct education and complete it by January 15th.

New Orientation checklist was developed for prior year's annual survey plan of correction and will continue to be utilized for all general orientation.

Audits to conducted – All new employees will be audited to ensure all general orientation requirements are met X 3 months.

Audit will be begin no later than 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

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

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

65f - Training Topics

5. 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.

Description of Violation

Direct care staff person D did not receive annual training in required topics for the 2024 training year to include:

(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.

Direct care staff person F did not receive annual training in required topics for the 2024 training year to include:

(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.

REPEAT VIOLATION [redacted] et. al.

Plan of Correction ***Accept [redacted] - 12/24/2025)***

Immediate Action – Staff Persons D and F will be trained per 2600.65 on medication self administration and meeting the needs of residents as described in preadmission screening form, assessment tool, medical evaluation and support plan. Action will be taken by HR Director and be completed by 1/15/2026.

Education to be completed - HR employees will be educated on annual training requirements for new employees as listed in 2600.65f. Healthcare Administrator will conduct education and complete it by January 15th

Audits to conducted – All employees will be audited to ensure 2025 annual education is assigned and completed per 2600.65f.

Audit will be conducted by 12/31/2025, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

65g - Annual Training Content

6. 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:
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Direct care staff person D did not receive required annual training for the 2024 training year to include:

(3) Resident Rights

(4) Mandatory reporting of abuse and neglect under The Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102).

(5) Falls and accident prevention.

Direct care staff person F did not receive required annual training for the 2024 training year to include:

(3) Resident Rights

(4) Mandatory reporting of abuse and neglect under The Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102).

(5) Falls and accident prevention.

REPEAT VIOLATION [redacted] et. al.

Plan of Correction ***Accept ([redacted] - 12/24/2025)***

Immediate Action – Direct Care Staff Persons D and F will receive training on Resident Rights, Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act and Falls and Accident Prevention. Action will be taken by HR Director and be completed by 1/15/2025.

Education to be completed – PC Administrator and HR department will be educated on all of the annual training requirements for staff and volunteers listed in 2600.65.g. Healthcare Administrator will conduct education and complete it by January 15th.

Audits to conducted – Facility will audit all employees to ensure that all required annual training has been completed for 2025.

Audit will be conducted by 12/31/2025, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

132f - Alternate Exit Routes

7. Requirements

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

Description of Violation

The exit route "Away from fire beyond fire doors to exit at stairwell 3" was the only exit route used for fire drills held

132f Alternate Exit Routes (continued)

in the Cedar Boulevard secured dementia care unit on dates to include:

- [redacted]

Plan of Correction ***Accept [redacted] - 12/24/2025)***

Immediate Action Past non compliance unable to be corrected. EVS will create a fire drill schedule for calendar year 2026 that meets all criteria listed in 2600.132.f. Director of EVS will complete by 1/15/2026.

Education to be completed Providence Point Safety committee will be educated on fire drill requirements listed within 2600.132.f. Healthcare Administrator will conduct education and complete it by January 15th.

Audits to conducted Monthly audit will be conducted X 3 months to ensure fire drills were held in accordance to 2026 schedule, ensuring they meet all requirements in 2600.132.g

Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

132g - Fire Drills Days/Times

8. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely conducts sleeping hours fire drills on personal care floors 2 and 3 at approximately the same time of night to include:

- [redacted]

Plan of Correction ***Accept [redacted] - 12/24/2025)***

Immediate Action Past non compliance unable to be corrected. EVS will create a fire drill schedule for calendar year 2026 that meets all criteria listed in 2600.132.g. Director of EVS will complete by 1/15/2026.

Education to be completed Providence Point Safety committee will be educated on fire drill requirements listed within 2600.132.g. Healthcare Administrator will conduct education and complete it by January 15th.

132g - Fire Drills Days/Times (continued)

Audits to conducted- Monthly audit will be conducted X 3 months to ensure fire drills were held in accordance to 2026 schedule, ensuring they meet all requirements in 2600.132.g

Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

141b1 - Annual Medical Evaluation

9. Requirements

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

Description of Violation

Resident [redacted] annual medical evaluation, dated [redacted], was missing the resident's pulse, blood pressure and temperature, those sections of the form were left blank.

Resident [redacted]s annual medical evaluation, dated [redacted] was missing the resident's height, weight, pulse rate, blood pressure, temperature, and there was no determination made in section for special health and dietary needs, those sections of the form were left blank. Additionally, the medical professional who signed the medical evaluation form did not print their name and did not include their medical professional license number.

Resident [redacted] annual medical evaluation, dated [redacted] was missing the resident's blood pressure and temperature, those sections of the form were left blank.

REPEAT VIOLATION [redacted] et. al.

Plan of Correction ***Accept ([redacted] - 12/24/2025)***

Immediate Action- Residents [redacted] and [redacted] will have a medical evaluation completed that is complete and meets all criteria listed in 2600.141.b.1. PC Nurse will complete by 1/15/2026.

Education to be completed – All nurses will be educated on Annual Medical Evaluation requirements listed within 2600.141b1. Healthcare Administrator will conduct education and complete it by January 15th.

Audits to conducted- Facility will audit annual medical evaluations for 2 random residents, each week X 8 weeks to ensure it is completed in its entirety per regulation 2600.141b1.

Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

183e - Storing Medications

10. 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

Resident #[redacted]'s [redacted] indicated a date opened of [redacted] and the pharmacy label indicated the medication would expire 28 days after opening or on [redacted]. However, resident #[redacted]s [redacted] was still on the second-floor personal care medication cart at approximately 2:35 p.m. on [redacted] and had been administered to the resident during the hour of sleep on dates ranging from [redacted] through [redacted]

Plan of Correction ***Accept ([redacted] - 12/24/2025)***

Immediate Action – Expired lantus pen has been appropriately discarded and replaced with proper lantus pen. Action was completed by PC LPN by 12/10/2025.

Education to be completed – All Nurses and Med Techs will be educated on ensuring expired medications are discarded immediately and not to administer expired medications to residents. Healthcare Administrator will conduct education and complete it by January 15th.

Audits to conducted – Med Carts will be audited weekly X 4 weeks and then monthly X 2 months to ensure there are no expired medications stored in the medication cart.

Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

185a - Implement Storage Procedures

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 [redacted] was not set to the current date or time. On [redacted] at approximately 2:23 p.m. the resident's glucometer indicated a date of [redacted] and a time of 7:11 p.m.

On [redacted] at approximately 9:00 a.m. resident [redacted] indicated a blood glucose reading of [redacted] However, resident #[redacted] December 2025 medication administration record documented a reading of [redacted] mg/dL on [redacted] between 7:00 a.m. and 11:00 a.m.

REPEAT VIOLATION [redacted] et. al.

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept [redacted] - 12/24/2025)***

Immediate Action : Resident [redacted] glucometer will be updated to indicate correct date and time. Unable to correct past deficient practice as it related to glucometer reading discrepancy. Action was completed by PC Nurse on 12/10/2025.

Education to be completed – All med techs and nurses will be educated on 2600.185.a and the importance of ensuring glucometer date and times are correct and glucometer readings match what is listed in the electronic health record. Healthcare Administrator will conduct education and complete it by January 15th.

Audits to conducted – 2 residents will be audited weekly X 8 weeks to ensure glucometer date and time is correct and glucometer readings in EHR match the glucometer readings.

Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

187a - Medication Record

12. Requirements

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

Description of Violation

Resident [redacted] December 2025 medication administration record indicated "[redacted], take one tablet by mouth twice a day, take one [redacted] with one 50mg tablet equal to 150mg once daily." However, resident [redacted] was prescribed [redacted] tablet, take one tablet by mouth once a day, take one 100mg tablet with one 50mg tablet equal to 150mg once daily.

REPEAT VIOLATION[redacted] et. al.

Plan of Correction ***Accept[redacted] - 12/24/2025)***

Immediate Action – Resident[redacted]s sertraline order was immediately corrected to reflect actual physician order. Action was completed by PC Nurse by 12/10/2025.

Education to be completed – LPN and Med Techs will be educated on requirements listed in 2600.187.a to ensure that the frequency of all medications is accurate and reflects the physician order. Healthcare Administrator will conduct education and complete it by January 15th.

187a - Medication Record (continued)

Audits to conducted- 2 residents will be audited weekly X 8 weeks to ensure the frequency of the medication listed on the MAR is correct and matches up with the frequency of the physician order.

Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented ([redacted] - 01/20/2026)

224a - Preadmission Screen Form

13. 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

There was no preadmission screening form completed for resident [redacted]. Resident [redacted] was admitted on [redacted].

REPEAT VIOLATION [redacted] et. al.

Plan of Correction ***Accept[redacted] - 12/24/2025)***

Immediate Action – Preadmission screen form was completed for resident [redacted]. Action will be completed by PC Nurse by 1/15/2026.

Education to be completed – Admission director and nurses will be educated on requirements of prescreen form as listed in 2600.224.a. Healthcare Administrator will conduct education and complete it by January 15th.

Healthcare Administrator will create new admission checklist to be completed for all new admissions to verify all required components are completed. Checklist will be created and put into place for all new admissions by 1/15/2026.

Audits to conducted- All new admissions x 3 months will be audited to ensure prescreen form was completed and meets all requirements listed in 2600.224.a.

Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

225a - Assessment 15 Days

14. Requirements

2600.

225a Assessment 15 Days *(continued)*

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 [redacted] was admitted to the Cedar Boulevard secured dementia care unit (SDCU) on [redacted] However, resident [redacted] initial assessment was completed on [redacted]. Additionally, resident [redacted] assessment dated [redacted] did not include the use of the bedside mobility device affixed to the right side of the resident's bed in resident room [redacted] of the Cedar Boulevard SDCU.

REPEAT VIOLATION [redacted] et. al.

Plan of Correction ***Accept [redacted] - 12/24/2025)***

Immediate Action Resident [redacted] assessment will be updated to reflect the use of the bedside mobility device. Action will be completed by PC nurse by 1/15/2026.

Education to be completed All nurses will be educated on requirements of 15 day assessment as listed in 2600.225a. Healthcare Administrator will conduct education and complete it by January 15th.

Healthcare Administrator will create new admission checklist to be completed for all new admissions to verify all required components are completed. Checklist will be created and put into place for all new admissions by 12/31/2025.

Audits to conducted All new admissions X 3 months will be audited to ensure initial assessment contains all required information and is complete within 15 days of admission.

Audits will begin no later 1/5/2025, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

227d - Support Plan Medical/Dental

15. Requirements

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

Description of Violation

Resident [redacted] Department requested assessment, dated [redacted], indicated the resident uses a bed enabler on the left side of the resident's hospital bed for turning and positioning. However, resident [redacted] support plan, also dated [redacted], did not indicate any risks associated with the use of the bedside mobility device, the resident's ability to use the device safely, or the specific device to be used and whether a cover is required to meet Food and Drug Administration guidelines.

227d Support Plan Medical/Dental (continued)

REPEAT VIOLATION [redacted] et. al.

Plan of Correction ***Accept [redacted] - 12/24/2025)***

Immediate Action Resident [redacted]'s support plan will be updated to include all required aspects as it relates to the use of the bed enabler. Action will be completed by PC nurse by 1/15/2026.

Education to be completed All nurses will be educated on all required elements of a residents support plan as described in 2600.227.d. Healthcare Administrator will conduct education and complete it by January 15th.

Audits to conducted 2 residents will be audited weekly x 8 weeks to ensure the support plan contains all required contents, with specific attention given to residents who utilize a bed enabler bar.

Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

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 [redacted] was admitted to the Cedar Boulevard secured dementia care unit on [redacted] However, there was no written cognitive screening documented on the Department's preadmission screening form, and there was no preadmission screening form completed for resident [redacted]

REPEAT VIOLATION [redacted] et. al.

Plan of Correction ***Accept [redacted] - 12/24/2025)***

Immediate Action Facility will complete a preadmission screen form for resident 5 that contains a cognitive screening assessment as required by 2600.231.c. Action will be completed by PC nurse by 1/15/2026.

Education to be completed all nurses will be educated on all preadmission screen requirements as listed in 2600.231.c. Healthcare Administrator will conduct education and complete it by January 15th.

Healthcare Administrator will create new admission checklist to be completed for all new admissions to verify all required components are completed. Checklist will be created and put into place for all new admissions by 1/15/2026.

Audits to conducted All new admissions to dementia unit will be audited X 3 months to ensure cognitive screening

231c Preadmission Screening (continued)

assessment was completed and part of the preadmission screen that was completed.

Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)

231e - No Objection Statement

17. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident [redacted] documentation of no objection to admission to home's Cedar Boulevard secured dementia care unit on [redacted] was not signed or dated by the resident.

REPEAT VIOLATION [redacted] et. al.

Plan of Correction ***Accept [redacted] - 12/24/2025)***

Immediate Action No objection statement for resident number 5 will be completed and entered into resident EHR. Action will be completed by PC Nurse by 1/15/2026.

Education to be completed Admissions director and nurses will be educated on the no objection statement for all residents being admitted to a memory support unit. Healthcare Administrator will conduct education and complete it by January 15th.

Healthcare Administrator will create new admission checklist to be completed for all new admissions to verify all required components are completed. Checklist will be created and put into place for all new admissions by 1/15/2026.

Audits to conducted All new admissions to a memory support unit X 3 months will be audited to ensure no objection statement is included upon admission.

Audits will begin no later 1/5/2026, be overseen by Healthcare Administrator. Plan of Correction items will be reviewed and discussed at Quarterly QA meeting on January 28th and then ongoing.

Licensee's Proposed Overall Completion Date: *01/15/2026*

Implemented [redacted] - 01/20/2026)