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

March 2, 2026

[redacted] ADMINISTRATOR
SACRED HEART ASSISTED LIVING BY SAUCON CREEK LLC
[redacted]

RE: SACRED HEART SENIOR LIVING BY SAUCON CREEK II
4801 SAUCON CREEK ROAD
CENTER VALLEY, PA, 18034
LICENSE/COC#: 22080

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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: *SACRED HEART SENIOR LIVING BY SAUCON CREEK II* **License #**: *22080* **License Expiration**: *08/03/2026*

Address: *4801 SAUCON CREEK ROAD, CENTER VALLEY, PA 18034*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *SACRED HEART ASSISTED LIVING BY SAUCON CREEK LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *03/20/2009* **Issued By**: *Upper Saucon Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *24* **Waking Staff**: *18*

Inspection Information

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

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

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served**: *12*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *36* **Residents Served**: *12*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *12*

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

Have Mobility Need: *12* **Have Physical Disability**: *0*

Inspections / Reviews

12/10/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/12/2026*

01/22/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/27/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/27/2026*

Inspections / Reviews *(continued)*

03/02/2026 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/27/2026*

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

82c - Locking Poisonous Materials

1. Requirements

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

At approximately 9:20 a.m. the utility room door in the dining area of the secured dementia care unit was unlocked, unattended and accessible to residents and contained a bottle of Pure Bright Germicidal Ultra Bleach, Automatic Dishwashing detergent, Diversey Shine Up lemon furniture polish, 4 bottles ECOLAB All Purpose Dishmachine Detergent, ZEP Professional Sprayer cleaner, Glance RTU Glass and Multi-Surface Spray, ECOLAB Medallion Stainless Steel Cleaner and Polish, and Diversey disinfectant cleaner with each containing a manufacturer's warning indicating "hazardous to humans and keep out of reach of children."

Plan of Correction ***Accept ([redacted] - 01/22/2026)***

PLAN OF CORRECTION FOR 2600.82.(c)
WEDGEWOOD INSPECTION DECEMBER 10TH 2025
Violation: 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: At approximately 9:20AM the utility room door in the dining area of the secured dementia unit was unlocked, unattended and accessible to residents and contained a bottle of Pure Bright Germicidal Ultra Bleach, Automatic Dishwashing detergent, Diversey Shine Up lemon furniture polish, 4 bottles ECOLAB All Purpose Dishmachine Detergent, ZEP Professional Sprayer cleaner, Glance TRU Glass and Multi-Surface Spray, ECOLAB Medallion Stainless Steel Cleaner and Polish and Diversey disinfectant cleaner with each containing a manufacture's warning indicating "hazardous to humans and keep out of reach of children."
Policy Statement: To ensure the safety and well-being of Wedgewood residents, all utility closets containing cleaning supplies and hazardous materials shall remain securely locked at all times. Access is restricted to authorized personnel only.
IMMEDIATE CORRECTION: The utility closet was immediately locked at the time of inspection.
Procedure
1. Lock Installation and Maintenance:
• All utility closets shall be equipped with secure, tamper-proof locks.
• Locks shall be checked monthly for proper functioning and replaced as needed.
2. Access Control:
• Only designated staff members (maintenance personnel, custodians, management) shall have keys or access codes.
• A logbook shall be maintained to record all entries and exits, including date, time, and personnel.
3. Key Management:
• Keys shall be stored in a secure, locked location when not in use.
• A designated staff member shall be responsible for issuing and retrieving keys. (Maintenance Director or Memory Unit Cook)
• Lost keys must be reported immediately, and locks rekeyed if necessary.
4. Resident Safety Measures:
• Signage shall be posted on or near the utility closet indicating that it is locked and access is restricted.
• Staff shall regularly remind residents, especially children, to avoid the utility closet.
5. Routine Checks:

82c - Locking Poisonous Materials (continued)

• Conduct weekly inspections to ensure all locks are secure and the closet remains locked.
• Any breaches or issues shall be documented and addressed immediately.
Plan of Correction
Objective: To promptly address any lapses in the locking of utility closets and prevent future occurrences.
Actions:
1. Immediate Lock Verification:
• Conduct a thorough inspection of all utility closets within 24 hours to confirm they are locked. Completed the same day of inspection 12/10/2025.
2. Staff Re-education:
• Re-train all staff on the importance of keeping utility closets locked, proper key management, and the safety protocols.
3. Enhanced Security Measures:
• Install additional signage and secure locking mechanisms if current locks are inadequate.
4. Monitoring and Documentation:
• Implement daily checklists for staff to verify closet locks during their shifts. Assigned to Maintenance Director and Memory Unit Cook.
• Document all inspections and corrective actions.
5. Follow-up:
• Schedule weekly audits for the next three months to ensure compliance. To be reviewed by the Administrator and conducted by Maintenance Director.
• Review and update policies as necessary based on audit findings.
Responsibility:
The Maintenance Director is responsible for implementing and overseeing this policy, ensuring staff compliance, and conducting regular audits.
Review with all departments who utilized the utility closets:
Dietary, Housekeeping, Maintenance
If the above plan of correction is accepted. The following protocol/procedure will be reviewed with Director of Maintenance, Dietary Supervisors and Housekeeping.
The following have been reviewed and understand the plan for securing/locking the utility closets within the building and the below designees will ensure to implement and assess to ensure compliance is maintained.
Administrator: [redacted], LPN
Signature: _____ Date: _____
Director of Maintenance: [redacted]
Signature: _____ Date: _____
Memory Unit Cook: [redacted]
Signature: _____ Date: _____
Housekeeping: Shine Crew, [redacted]
Signature: _____ Date: _____

Licensee's Proposed Overall Completion Date: *01/12/2026*

Implemented ([redacted] - 03/01/2026)

96a - First Aid Kit

2. Requirements

96a - First Aid Kit *(continued)*

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

At approximately 3:45 p.m., the first aid kit in the medication room did not include a thermometer.

Plan of Correction ***Accept (- 01/22/2026)***

PLAN OF CORRECTION FORE 2600.96.(a)
WEDGEWOOD INSPECTION DECEMBER 10TH, 2025
Violation 2600.96.(a)
The home shall a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.
At approximately 3:45pm, the first aid kit in the medication room did not include a thermometer.
Policy Statement: To ensure prompt and effective response to health emergencies, a functional thermometer shall be maintained in the med room first aid kit at all times. This enables accurate assessment of residents' and staff members' health conditions.
IMMEDIATE CORRECTION: A thermometer was ordered and place in the first aid kit 12/12/2025.
Procedure
1. Thermometer Supply and Maintenance:
• A digital thermometer shall be kept in the med room first aid kit at all times.
• The thermometer shall be checked weekly for functionality and cleanliness.
• Any thermometer found to be broken, malfunctioning, or expired shall be replaced immediately.
2. Inventory Checks:
• The med room shall be inspected weekly to ensure the thermometer is present and in working order.
• A designated staff member shall document the inspection on a checklist.
3. Usage Protocol:
• Staff shall be trained on how to properly use and disinfect the thermometer.
• After use, the thermometer shall be cleaned and stored back in the med kit.
4. Reporting and Replacement:
• Any missing or defective thermometer shall be reported to the supervisor within 24 hours.
• Replacement shall be initiated within 48 hours.
Plan of Correction
Objective: To address the current absence of a thermometer in the med room first aid kit and prevent future lapses.
Actions:
1. Immediate Replacement:
• Obtain and place a new, fully functional thermometer in the med room first aid kit within 24 hours. Completed on 12/12/2025.
2. Staff Re-education:
• Re-train staff on the importance of having a thermometer in the first aid kit and proper maintenance procedures.
3. Regular Monitoring
• Implement a weekly checklist to verify the presence and functionality of the thermometer. Assigned to LPN Wellness Director.
• Document all inspections and any actions taken.
4. Policy Update:
• Update inventory procedures to include routine checks of all first aid supplies, including thermometers.
5. Follow-up

96a - First Aid Kit (continued)

• Conduct weekly audits over the next month to ensure ongoing compliance. Assigned to the LPN Wellness Director.
• Address any issues immediately.
Responsibility: The LPN Wellness Director shall oversee the inventory, maintenance, and documentation of the thermometer.
If the above plan of correction is accepted. The following protocol/procedure will be reviewed with the LPN Wellness Director.
The following have been reviewed and understand the plan for first aid kits to be completed stock with the requirements including a thermometer and the below designees will ensure to implement and assess to ensure compliance is maintained.
Administrator: [redacted] *LPN*
Signature: _____ Date: _____
LPN Wellness Director, [redacted] *. LPN*
Signature: _____ Date: _____

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented ([redacted] - 03/01/2026)

125a - Combustible Storage

3. Requirements

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

Description of Violation

At approximately 9:20 a.m. the following things were noted within 3 feet of the hot water heater located in the electrical room in the dining room of the secured dementia care unit: 3 squares of carpeting, a five and one gallon of paint, tile and stone floor cleaner, a roll of tape, and a box of lightbulbs.

Plan of Correction ***Accept ([redacted] - 01/22/2026)***

PLAN OF CORRECTION FOR 2600.125.(a)
WEDGEWOOD INSPECTION DECEMBER 10TH, 2025
Violation: 2600.125.(a)
Combustible and flammable materials may not be located near heat sources or hot water heaters.
At approximately 9:20am the following things were noted within 3 feet of the hot water heater located in the electrical room in the dining room of the secured dementia care unit: 3 squares of carpet, a five gallon of paint, tile and stone floor cleaner, a roll of tape, and a box of light bulbs.
Policy Statement: To maintain a safe environment and prevent fire hazards, the utility closet housing water heaters shall not contain any flammable materials, chemicals, paints, or cleaning supplies. The room must be kept free of any items that could pose a safety risk.
IMMEDIATE CORRECTIVE ACTION: Flammable materials were removed from the water heater closet the day of inspection 12/10/25.
Procedure
1. Room Use and Storage Restrictions:
• The water heater utility room is designated solely for housing the water heater and related plumbing and electrical components.
• No flammable substances, chemicals, paints, cleaning supplies, or other hazardous materials shall be stored

125a - Combustible Storage (continued)

within this room at any time.
2. Inspection and Monitoring:
• The room shall be inspected weekly by maintenance staff to ensure it remains free of unauthorized items.
• Any items found stored in the utility room shall be removed immediately.
3. Staff Training:
• All staff responsible for maintenance and storage shall be trained on the importance of keeping this room clear of flammable and hazardous materials.
• Training will include identification of prohibited items and proper storage procedures.
4. Signage:
• Signage shall be posted on or near the utility room door indicating that only authorized personnel and approved equipment are permitted inside.
5. Incident Reporting:
• Any violations or safety concerns shall be reported immediately to management for corrective action. Report to Administrator.
Plan of Correction
Objective: To address current violations and ensure ongoing compliance with safety standards regarding storage in the water heater utility room.
Actions:
1. Immediate Removal:
• Conduct an immediate inspection of the utility room and remove any flammable or hazardous materials stored within. Completed day of inspection 12/10/2025.
• Dispose of or relocate these items to designated safe storage areas.
• See attached photo
2. Staff Re-education:
• Re-train all relevant staff on proper storage protocols and the importance of keeping the utility room clear. This also includes outside workers such as plumbers, painters, etc.
• Emphasize the fire safety risks associated with storing flammable materials near water heaters.
3. Regular Inspections:
• Implement weekly inspections to verify the utility room remains free of unauthorized items.
• Document inspections and any corrective actions taken.
4. Signage and Access Control:
• Ensure clear signage is posted.
• Limit access to authorized personnel only.
5. Follow-up:
• Conduct monthly audits for the next three months to ensure continued compliance. Assigned to the Director of Maintenance and to review with the Administrator.
• Address any violations immediately and document corrective actions.
Responsibility: Maintenance Director shall oversee implementation, staff training, inspections, and compliance monitoring and report to the Administrator.
If the above plan of correction is accepted. The following protocol/procedure will be reviewed with the Maintenance Director.
The following have been reviewed and understand the plan to ensure all combustible materials are stored properly and away from fire hazards which includes the water heater closets and the below designees will ensure to implement and assess to ensure compliance is maintained.
Administrator: [redacted]*, LPN*

125a - Combustible Storage (continued)

Signature: _____ Date: _____
Director of Maintenance, [redacted]
Signature: _____ Date: _____

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented (- 03/01/2026)

132e - Fire Drill Sleeping Hours

4. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The homes most recent sleeping hours fire drill was conducted on 11/13/25 at 12:17 a.m., the previous one was conducted on 5/7/25 at 4:22 a.m.

Plan of Correction ***Accept (- 01/22/2026)***

PLAN OF CORRECTION FOR 2600.132.(e)
WEDGEWOOD INSPECTION DECEMBER 10TH, 2025
2600.132.(e) A fire drill shall be held during sleeping hours once every 6 months.
The homes most recent sleeping hours fire drill was conducted on 11/13/2025 at 12:17am, the previous on was conducted on 5/7/2025 at 4:22am.
Policy Statement: To comply with regulatory requirements and ensure resident safety, night-time fire drills shall be conducted precisely every six months. Drills may occur a few days before the scheduled six-month anniversary but must not be conducted after the previous drill date, maintaining a strict six-month interval.
Procedure
1. Scheduling of Fire Drills:
• The Director of Maintenance shall establish a biennial schedule, with drills planned for May and November each year.
• The schedule shall be documented and communicated to all relevant staff at least one month in advance.
2. Timing of Drills:
• The actual drill date should be within a few days prior to the six-month mark but cannot be after the previous drill date. For example, if the last drill was on November 13, the next should be scheduled on or before May 13.
• The date shall be recorded and tracked using a fire drill log or schedule.
Tentative Schedule for night time fire drills starting from November 13th, 2025:
May 13th, 2026 (or a few days before, if it is held on May 11th, 2026 the next night time fire drill would be November 11th, 2026)
November 13th, 2026 (or six months from the May scheduled night time fire drill)
3. Execution of Drills:
• All staff members take part in unannounced drills scheduled randomly during their work shifts.
• The drill shall be conducted during nighttime hours, as specified in policy, with documentation of the time, participants, and observations.
4. Documentation:
• After each drill, a report shall be completed noting the date, time, staff participation, any issues, and corrective actions needed.

132e - Fire Drill Sleeping Hours (continued)

• Records shall be maintained for review and regulatory compliance.
5. Review and Adjustment:
• The Maintenance Director shall review the schedule annually and adjust as necessary to ensure compliance with the six-month interval requirement with the Administrator.
Plan of Correction
Objective: To address any lapses in the fire drill schedule and ensure future drills occur exactly six months apart.
Actions:
1. Immediate Review:
• Review the last fire drill date to determine the correct upcoming drill date, ensuring it occurs within the allowable window (a few days before the six-month anniversary but not after the previous drill). Starting with November 13, 2025 date of last night time fire drill the tentative schedule will be as follows:
• May 13th, 2026 (or a few days before, i.e. if it is held on May 11th, 2026 the next night time fire drill would be November 11th, 2026)
• November 13th, 2026 (or six months from the May scheduled night time fire drill)
2. Rescheduling and Documentation:
• Reschedule any missed or improperly timed drills to align with the six-month interval.
• Document the new schedule and notify all staff.
3. Staff Training and Communication:
• Re-educate staff responsible for scheduling and conducting fire drills on the importance of maintaining the strict six-month interval.
• Reinforce the policy on timing flexibility (a few days before, not after).
4. Monitoring:
• Implement a tracking system (calendar or spreadsheet) to monitor upcoming drill dates.
• Conduct monthly reviews to ensure upcoming drills are scheduled correctly.
5. Follow-up:
• Audit the fire drill schedule quarterly for the next year to verify compliance.
• Address any deviations immediately, adjusting schedules as needed.
Responsibility: The Maintenance Director shall oversee scheduling, documentation, and compliance.
If the above plan of correction is accepted. The following protocol/procedure will be reviewed with the Maintenance Director.
The following have been reviewed and understand the plan to ensure the six month nightly fire drills are scheduled correctly to meet the six month requirement and the below designees will ensure to implement and assess to ensure compliance is maintained.
Administrator: [redacted] *LPN*
Signature: _____ Date: _____
Director of Maintenance, [redacted]
Signature: _____ Date: _____

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented ([redacted] - 03/01/2026)

162c - Menus Posted

5. Requirements

2600.

162c - Menus Posted *(continued)*

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

The menus posted the dining room were dated 11/30-12/6/25 and 12/7-12/13/25.

Plan of Correction ***Accept (- 01/22/2026)***

PLAN OF CORRECTION FOR 2600.162.(c)
WEDGEWOOD INSPECTION DECEMBER 10TH, 2025
Violation 2600.162.(c)
Menus, stating the specific food being served at each meal, shall be prepared 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.
The menus posted in the dining room were dated 11/30-12/6/2025 and 12/7-12/13/2025.
IMMEDIATE PLAN OF CORRECTION: The correct menus dated 12/7-12/13/2025 and 12/14-12/20/2025 were posted correctly on 12/10/2025.
Policy Statement: To promote transparency and resident satisfaction, the current week's dietary menu and the following week's menu shall be displayed in a prominent location accessible to all residents for review at all times.
Procedure
1. Menu Preparation:
• The dietary department shall prepare and finalize the weekly menu at least one week in advance.
• The menu shall include all meal options, special diets, and any seasonal or special event offerings.
2. Menu Display:
• The current week's menu shall be posted in a designated common area (e.g., dining room, resident lounge, or bulletin board) by the beginning of each week.
• The following week's menu shall be posted immediately after the current week's menu is displayed.
3. Accessibility and Clarity:
• Menus shall be printed in large, clear font and posted in an easily visible location.
• The menus shall be accessible to residents with visual or cognitive impairments (e.g., large print, Braille if applicable).
4. Review and Updating:
• Staff shall ensure menus are current, accurate, and free of errors at all times.
• Any changes or substitutions shall be reflected promptly and communicated to residents.
5. Resident Feedback:
• Residents shall be encouraged to provide feedback or request alternative options if necessary.
• Feedback shall be documented and addressed by the dietary supervisor.
Plan of Correction
Objective: To correct any current lapses in displaying the weekly menus and establish ongoing compliance.
Actions:
1. Immediate Action:
• Verify that the current week's and next week's menus are displayed in the designated area.
• If either menu is missing or outdated, print and post the correct menus immediately. This is completed on 12/10/2025.
2. Staff Re-education:
• Re-train dietary staff and relevant personnel on the importance of timely menu posting and proper display procedures.
• Clarify the schedule for preparing and posting menus at least one week in advance.

162c - Menus Posted (continued)

3. Establish Routine Checks:
• Implement daily or weekly checks by staff to ensure menus are current and properly posted.
• Document these checks in a monitoring log.
4. Resident Communication:
• Inform residents of the posting location and encourage their review and feedback.
5. Ongoing Monitoring:
• Conduct monthly audits to verify menus are consistently displayed as required.
• Address any issues immediately and adjust procedures as needed.
Responsibility:
The Executive Chef and Memory Unit Executive Chef are responsible for menu preparation, posting, and ensuring ongoing compliance with this policy.
If the above plan of correction is accepted. The following protocol/procedure will be reviewed with the Executive Chef and Memory Unit Chef.
The following have been reviewed and understand the plan to ensure the menus are displayed to show the current and following week's menu for displayed and the below designees will ensure to implement and assess to ensure compliance is maintained.
Administrator: [redacted] *LPN*
Signature: _____ Date: _____
Executive Chef, [redacted]
Signature: _____ Date: _____
Memory Unit Chef, [redacted]
Signature: _____ Date: _____

Licensee's Proposed Overall Completion Date: *01/09/2026*

Implemented ([redacted] - 03/01/2026)

185a - Implement Storage Procedures

6. 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 #2 is prescribed Tramadol HCL 50 mg tablet. The resident's medication administration record indicates that on 12/10/25 at 9:00 a.m. Staff person B administered Tramadol HCL 50 mg table to the resident; however, this is not indicated on the home's narcotics log sheet.

Plan of Correction ***Accept ([redacted] - 01/22/2026)***

PLAN OF CORRECTION FOR 2600.185(a)
WEDGEWOOD INSPECTION DECEMBER 10TH 2025
Violation 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.

Resident #2 is prescribed Tramadol HCL 50mg tablet. The resident's medication administration record indicates that on 12/10/2025 at 9:00AM Staff person B administered Tramadol HCL 50mg table to the resident; however, this is

185a - Implement Storage Procedures (continued)

not indicated on the home's narcotics log sheet.

IMMEDIATE PLAN OF CORRECTION: LPN Wellness Director reviewed with Staff person B the 5 Rights of Medication Administration and reviewed the narcotic log documentation.
Note: A quarterly nursing meeting was held on 12/11/2025 and Medication Administration was reviewed.
Please see attached minutes, policy review and attendance sheet.

Policy Statement:
To ensure compliance with medication administration standards and regulatory requirements, Med Techs shall accurately document all medications, including narcotics, in the EMR system (QuickMar) and on the Narcotic Sheet. Documentation must include the date and time of administration to verify proper medication delivery to residents.
Procedure
1. Medication Dispensing:
• When dispensing medication, Med Techs shall verify the resident's identity and medication order before administration.
• Med Techs shall dispense the medication following facility protocols.
2. Documentation in QuickMar:
• Immediately upon administering medication, Med Techs shall log the medication in QuickMar, recording the exact date, time, medication name, dosage, and resident's name.
• For narcotics, additional details such as the signature or initials of the Med Tech shall be entered as required.
3. Documentation on Narcotic Sheet:
• Simultaneously, Med Techs shall record the medication in the Narcotic Sheet, noting the date, time, medication name, dosage, and signature or initials.
• The Narcotic Sheet shall be maintained securely and reviewed regularly for accuracy.
4. Verification:
• Before completing documentation, Med Techs shall verify entries for accuracy and completeness.
• Any discrepancies or errors shall be corrected immediately following facility procedures, with documentation of the correction.
5. Compliance Monitoring:
• LPN Wellness Director shall periodically audit medication records and documentation practices to ensure compliance with this policy.
Plan of Correction
Objective: To address current documentation deficiencies and establish ongoing compliance with medication administration documentation standards.
Actions:
1. Immediate Review:
• Conduct an audit of recent medication administration records to identify any missing or incorrect entries in QuickMar and the Narcotic Sheet.
• Review any discrepancies immediately with Med Techs and Administrator.
2. Staff Education and Re-Training:
• Re-train all Med Techs on the importance of timely and accurate documentation in QuickMar and on the Narcotic Sheet.
• Emphasize the requirement to document immediately after medication administration, including all necessary details such as date, time, and signature.
3. Reinforce Documentation Procedures:

185a - Implement Storage Procedures (continued)

• Reinforce the steps for verifying resident identity, medication, and proper documentation during medication pass.
• Provide refresher training sessions and reference materials as needed.
4. Implement Monitoring Systems:
• Establish a schedule for regular audits (weekly or bi-weekly) of medication documentation records.
• Use audit findings to identify areas for improvement and provide feedback to staff.
5. Ongoing Compliance:
• Continue periodic staff assessments and audits for the next three months to ensure adherence to documentation policies.
• Address any deficiencies immediately, with additional training if necessary.
Responsibility:
The LPN Wellness Director shall oversee documentation compliance, staff training, and audit processes.
If the above plan of correction is accepted. The following protocol/procedure will be reviewed with the LPN Wellness Director. A Review of the 5 Rights of Medication Administration and EMR Review (QuickMar) and documentation in narcotics log will be reviewed with all persons employed at facility who are certified to administer medications is tentatively scheduled for 1/15/26 and attendance log for training will be submitted for inspector review.
The following have been reviewed and understand the plan to ensure med techs/nurses administering medications are following the 5 Rights of Medication Administration and EMR review (QuickMar) for the procedures of administering and documenting medications administered after dispensed to resident the below designees will ensure to implement and assess to ensure compliance is maintained.
Administrator: [redacted] *LPN*
Signature: _____ Date: _____
LPN Wellness Director, [redacted] *. LPN*
Signature: _____ Date: _____

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

Implemented (- 03/01/2026)

187b - Date/Time of Medication Admin.

7. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is prescribed Alprazolam 25 mg Tablet. On 12/8/25 the home's narcotics log indicates the resident was administered 2 Alprazolam 25 mg Tablets at 9:30 p.m. by Staff person A, however, it was not indicated on the resident's medication administration record.

Plan of Correction ***Accept (- 01/22/2026)***

PLAN OF CORRECTION FOR 2600.187.(b)
WEDGEWOOD INSPECTION DECEMBER 10TH, 2025
Violation: 2600.187.b
The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.
Resident #1 is prescribed Alprazolam 25mg Tablet. On 12/8/25 the home's narcotics log indicates the resident was administered 2 Alprazolam 25mg Tablets at 9:30pm by Staff person A, however, it was not indicated on the resident's medication administration record.

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

Policy Statement:
To ensure compliance with medication administration standards and regulatory requirements, Med Techs shall accurately document all medications, including narcotics, in the EMR system (QuickMar) and on the Narcotic Sheet. Documentation must include the date and time of administration to verify proper medication delivery to residents.
Root Cause Analysis: The error was due to documentation inaccuracies and failure to adhere to the five rights of medication administration. The MAR entries were not verified against actual medication administration, and staff may have misunderstood or overlooked the importance of real-time documentation directly after medication administration.
IMMEDIATE PLAN OF CORRECTION: LPN Wellness Director reviewed with Staff person A the 5 Rights of Medication Administration and reviewed documentation of medications on 12/10/2025.
Note: A quarterly nursing meeting was held on 12/11/2025 and Medication Administration was reviewed. Please see attached minutes, policy review and attendance sheet.
Plan of Correction for Training and Prevention:
1. Retraining of Medication Technicians and Nursing Staff:
• All medication staff (med techs and nurses) will receive refresher training on the Five Rights of Medication Administration (Right Resident, Right Medication, Right Dose, Right Time, Right Route).
• The training will emphasize the importance of documenting medication administration immediately after giving the medication, in accordance with regulation 2600.187.b.
• Staff will be instructed on the proper use of the EMR system, Quickmar, including how to accurately record medication administration in real-time.
2. Review and Reinforcement of Policies:
• The facility's medication administration policies and procedures will be reviewed with all staff, highlighting the importance of timely and accurate documentation.
• Staff will be provided with quick reference guides on documentation procedures and the use of Quickmar.
3. System and Process Improvements:
• Implement periodic audits of medication administration records to ensure documentation accuracy and timeliness.
• LPN Wellness Director will conduct weekly/random checks to verify compliance with documentation standards.
4. Monitoring and Quality Assurance:
• The LPN Wellness Director will oversee ongoing compliance and conduct regular chart audits.
• Any discrepancies or documentation errors will be addressed promptly with additional education or corrective actions.
If the above plan of correction is accepted. The following protocol/policy will be reviewed by the designees. The review of the 5 Rights of Medication Administration and EMR review for procedure to document medication administered after dispensed to resident tentative and attendance log for training will be submitted for inspector review. The tentatively scheduled review is for 1/15/26 and attendance log for training will be submitted for inspector review.
The following have reviewed and understand the plan for the review of the 5 Rights of Medication Administration and EMR review for procedure to document medication administered after dispensed to resident and the below designees will ensure to implement and maintain compliance.
Administrator: [redacted] *LPN*
Signature: _____ Date:_____
LPN Wellness Director: [redacted]*, LPN*
Signature: _____ Date:_____

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

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

Implemented (- 03/01/2026)