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

April 13, 2026

BRANDYWINE PA HEALTHCARE OPERATIONS LLC

RE: SILVER SPRINGS AT EAST NORRITON
2101 NEW HOPE STREET
EAST NORRITON, PA, 19401
LICENSE/COC#: 15179

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/15/2025, 12/16/2025 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: *SILVER SPRINGS AT EAST NORRITON* **License #**: *15179* **License Expiration**: *02/14/2026*

Address: *2101 NEW HOPE STREET, EAST NORRITON, PA 19401*

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

Administrator

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

Legal Entity

Name: *BRANDYWINE PA HEALTHCARE OPERATIONS LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/27/2003* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *109* **Waking Staff**: *82*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *12/16/2025*

Inspection Dates and Department Representative

12/15/2025 - On-Site:
12/16/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *245* **Residents Served**: *68*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *50* **Residents Served**: *20*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *0*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *3*
Have Mobility Need: *41* **Have Physical Disability**: *0*

Inspections / Reviews

12/15/2025 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/07/2026*

02/06/2026 - POC Submission

Submitted By: **Date Submitted**: *02/26/2026*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/10/2026*

Inspections / Reviews *(continued)*

02/09/2026 POC Submission

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

Reviewer: [REDACTED] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/28/2026*

04/13/2026 Document Submission

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

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On , at approximately 7:25 pm, resident was in a physical altercation with resident in resident room. The home did not report this incident to the Department until at 8:00 pm.

Resident was unresponsive in room and was pronounced by hospice. The home did submit an incident report to the Department, but it failed to include the date of the incident, the submission date, and the time.

Repeat Violation et al,

Plan of Correction ***Accept - 02/06/2026)***

PLAN OF CORRECTION
Tag: Incident Reporting / Timely & Complete Reporting
Repeat Violation Dates: et al,
Current Citation Date(s): 11/21/25 & 11/24/25

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1. Immediate Corrective Action (Completed)
• The incident involving Resident and Resident was reviewed with the Executive Director and Director of Wellness immediately upon identification of the reporting delay.
• The incident involving Resident was reviewed, and staff were counseled on required elements for DHS incident reporting (incident date, submission date, and time).
• All current supervisory staff were re-educated verbally on:
o DHS incident reporting timeframes
o Required content for incident reports
• Immediate correction completed by: Executive Director
• Date of completion: no later than 2/15/2026

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2. Root Cause Analysis
The investigation determined that:
• There was inconsistent understanding among leadership and nursing staff regarding:
o DHS reporting timeframes
o Required documentation elements for incident submissions
• There was no standardized secondary review process in place to ensure incident reports were complete and submitted timely.
• Repeat violations indicate a systemic breakdown, not an isolated incident.

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3. Corrective Actions to Prevent Recurrence
A. Policy & Procedure Enhancement
• The Incident Reporting Policy has been revised to clearly outline:
o Events requiring DHS notification

16c - Written Incident Report (continued)

o 24-hour reporting requirements
o Mandatory data elements (incident date, time, submission date/time, description, involved parties)
• Policy now includes a two-step review process prior to submission.
• Responsible Party: Executive Director
• Completion Date: No later than 2/15/2026

B. Mandatory Staff Training Program (Corrective Training)
Training Title:
Incident Reporting, Abuse Prevention & DHS Notification Requirements
Training Content Includes:
• Definition of reportable incidents per PA 2600
• 24-hour reporting requirements
• Difference between internal incident reports vs. DHS submissions
• Required elements of a complete DHS report
• Documentation accuracy and timeliness
• Case examples using actual (de-identified) scenarios
• Consequences of late or incomplete reporting
• Chain of responsibility and escalation process
Who Will Be Trained:
• Executive Director
• Director of Wellness
• LPNs/RNs
• Supervisors
• Med Techs
• Lead Care Staff
Training Format:
• Instructor-led in-service
• Written materials
• Post-training competency quiz (minimum 90% passing score)
Training Completion Timeline:
• Initial training completed by: 2/26/2026
• New hires trained during orientation going forward
Responsible Party:
• Executive Director / Director of Wellness

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4. Monitoring & Quality Assurance
A. Incident Reporting Audit Tool
• An Incident Reporting Audit Tool has been implemented.
• Audits will review:
o Timeliness of reporting
o Completeness of DHS submissions
o Accuracy of incident details
Audit Schedule:
• Weekly audits for 30 days
• Monthly audits for 3 months

16c - Written Incident Report (continued)

• Quarterly audits thereafter
Responsible Party:
• Executive Director or Designee

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B. Leadership Oversight
• All DHS incident reports must be reviewed and approved by the Executive Director or designee prior to submission.
• Any missing or late reports will result in:
o Immediate corrective counseling
o Retraining as needed

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5. Responsible Parties Summary
Task Responsible Party
Policy revision Executive Director /Designee
Staff training Executive Director / Director of Wellness
Incident audits Executive Director / Designee
Ongoing monitoring Executive Director/ Designee

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6. Date of Full Compliance Expected Date of Compliance: 2/15/2026
Audit Schedule

Weekly × 30 days

Monthly × 3 months

Quarterly ongoing

Responsible: Executive Director / Designee

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented [redacted] - 04/13/2026)

17 - Record Confidentiality

2. Requirements

2600.

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

Description of Violation

On [redacted] at approximately 10:36 am, the wellness office on the first floor with the resident's assessment and support plan was unlocked, unattended, and accessible to all residents and visitors.

17 - Record Confidentiality *(continued)*

Plan of Correction ***Accept [redacted] 02/06/2026)***

PLAN OF CORRECTION

Tag: Resident Record Confidentiality / Secure Storage of Resident Records
Citation Date: 12/15/25
Time Observed: Approximately 10:36 a.m.
Regulatory Authority: 55 Pa. Code §2600.17, §2600.52, §2600.190

1. Immediate Corrective Action 01/12/2026

Keypad locks were installed on all wellness office doors immediately upon identification of the deficiency.

All wellness offices containing resident assessments and support plans are now secured at all times, preventing unauthorized access by residents or visitors.

Resident records were reviewed and confirmed to be secure and intact, with no evidence of unauthorized access.

Date of completion: 1/12/2026

2. Root Cause Analysis

The investigation determined that:

The wellness office was left unlocked and unattended due to human error and lack of a fail-safe physical security control.

Reliance on staff memory alone was insufficient to ensure continuous record security.

There was a need for engineering controls in addition to staff education to ensure compliance.

3. Corrective Actions to Prevent Recurrence
A. Physical Security Enhancement

Keypad locks installed on all wellness office doors.

Only authorized staff are issued access codes.

Codes are changed as needed when staff separate from employment.

Responsible Party: Executive Director / Maintenance Director

Completion Date: 1/12/2026

B. Policy Review & Reinforcement

17 - Record Confidentiality (continued)

The Confidentiality and Secure Storage of Resident Records Policy was reviewed and reinforced with all applicable staff.

Policy clarifies that:

Offices containing resident records must remain secured at all times

Keypad locks do not replace staff accountability

Responsible Party: Executive Director/Designee

Completion Date: 01/12/2026

4. Mandatory Staff Training
Training Title

Resident Confidentiality & Secure Record Handling

Training Content Includes

Resident rights to privacy and confidentiality (§2600.52)

Secure storage requirements for resident records (§2600.17)

Proper use of keypad locks and access control

Prohibition of sharing access codes

Responsibilities during brief absences, emergencies, and shift changes

Consequences of non-compliance

Staff Required to Attend

Executive Director

Director of Wellness

Nurses

Wellness staff

Supervisors

17 - Record Confidentiality (continued)

Any staff with access to resident records

Training Format

Instructor-led in-service

Policy review

Written acknowledgment of understanding

Training Completion Timeline Complete no later than 2/15/2026

Initial training completed by: 02/15/2026

New hires trained during orientation

Responsible Party

Executive Director / Director of Wellness/Designee

5. Monitoring & Quality Assurance
A. Record Security Audit Tool

A Record Security Audit Tool has been implemented to verify:

Wellness office doors remain locked

Access codes are not shared

Audit Schedule

Daily spot checks for 14 days

Weekly audits for 30 days

Monthly audits for 3 months

Quarterly audits thereafter

Responsible Party

Executive Director or Designee

B. Corrective Action for Non-Compliance

17 - Record Confidentiality (continued)

Any unsecured records or violations identified will result in:

Immediate correction

Staff counseling

Retraining

Progressive discipline if repeated
Date of Full Compliance

Expected Date of Compliance: 2/15/2026
Audit Schedule

Daily × 14 days

Weekly × 30 days

Monthly × 3 months

Quarterly ongoing

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented - 04/13/2026)

42b - Abuse

3. Requirements

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

Description of Violation

On at approximately 7:25 pm, a private aide working in memory care unit Reflections was yelling for help from resident s room after observed resident who is in a wheelchair, pulling resident down and hitting the resident in the arm and head. The private aide heard resident say, "Stop, don't do this." At the time of this incident there were 20 residents present in Reflections and only one staff person. Staff person A, was assisting another resident to their room, and staff person B was late coming to work. As staff person B was getting off the elevator heard the aid yelling and went to the resident's room to help. Staff person B observed resident on the floor and resident holding the resident's arm. Staff person B asked resident to let go of resident s arm. Resident did let go and stated " why people keep coming into my room".
Staff person B proceeded to call a nurse, staff person C to assess both residents. A body examination completed by staff person C indicated resident had scattered small red spots to the left lower are, red area to left hand near pinky and ring finger, left and right knee had areas of redness and abrasions, redness to right inner forearm, and abrasions near side left under arm. Resident had a nose bleed no other injuries note.
According to resident support plan, the resident has poor safety awareness and needs to be redirected at all times. According to resident s support plan, resident requires extensive supervision with two-hour checks, for

42b - Abuse (continued)

agitation, the resident becomes anxious when people are around or too close.

Repeat Violation [redacted] et.al.

Plan of Correction ***Accept [redacted] - 02/06/2026)***

PLAN OF CORRECTION

Tag: Resident Protection / Adequate Supervision / Resident-to-Resident Abuse
Citation Date: 11/21/25
Time Observed: Approximately 7:25 p.m.
Location: Reflections – Memory Care Unit
Repeat Violation Dates: 04/28/25 et al.
Regulatory Authority: 55 Pa. Code §2600.15, §2600.186, §2600.190

1. Immediate Corrective Action (Completed at time of incident)

Both residents were immediately separated and assessed by licensed nursing staff.

Resident [redacted] received a full body assessment and appropriate follow-up care.

Resident [redacted] was assessed for injury and behavioral triggers.

The incident was reported to DHS in accordance with reporting requirements.

Memory Care staffing coverage was immediately reviewed to ensure no unit is left with a single staff member.

Immediate corrective action completed by: Supervisor on duty

Date of completion: 11/21/25

2. Protection of Residents During Correction

Resident [redacted] was placed on increased supervision pending review of behaviors.

Resident [redacted] received enhanced redirection support and supervision.

Care assignments were adjusted to prevent unsupervised interactions between the residents.

Both residents' representatives were notified.

3. Root Cause Analysis

The investigation determined that:

42b - Abuse (continued)

Inadequate staffing coverage occurred when one staff member was late and another was assisting a resident.

Memory Care supervision requirements were not consistently aligned with resident support plans.

Staff required additional training on:

Managing resident-to-resident altercations

Behavioral triggers in dementia

Immediate intervention techniques

The repeat nature of the citation indicates a systemic supervision and staffing oversight issue, not an isolated event.

4. Corrective Actions to Prevent Recurrence
A. Staffing Controls & Coverage

Minimum staffing coverage at all times

No Memory Care unit left with a single staff member

Late staff arrivals now require immediate leadership notification and coverage replacement.

Responsible Party: Executive Director / Scheduler/Designee

Completion Date: 2/15/2026

B. Support Plan Review & Updates

Both residents' support plans were reviewed and updated to reflect:

Increased supervision needs

Identified behavioral triggers

Specific redirection and intervention strategies

Support plans reviewed with direct care staff.

Responsible Party: Director of Wellness

Completion Date: 11/26/25

5. Mandatory Staff Training (Corrective Training)
Training Title

42b - Abuse (continued)

Resident-to-Resident Abuse Prevention, Dementia Behaviors & Adequate Supervision

Training Content Includes
1. Resident Rights & Protection (§2600.186)

Freedom from abuse

Right to safe living environment

2. Resident-to-Resident Altercations

Early warning signs

Intervention techniques

De-escalation strategies

Safe separation methods

3. Dementia-Related Behaviors

Agitation and anxiety triggers

Poor safety awareness

Territorial behaviors (room intrusion)

4. Supervision & Staffing Responsibilities

Aligning staffing with resident acuity

Never leaving Memory Care unattended

Escalation when staffing gaps occur

5. Immediate Response Protocol

What to do when an altercation occurs

Calling for assistance

Documentation and reporting requirements

Staff Required to Attend

42b - Abuse (continued)

All Memory Care staff

Nurses

Supervisors

Agency and private aides

Leadership staff
Training Format

Instructor-led in-service

Competency validation

Written acknowledgment

Training Completion Timeline

Initial training completed by: 02/15/2026

New hires trained during orientation

Annual refresher required

Responsible Party

Executive Director / Director of Wellness/Designee

6. Monitoring & Quality Assurance
A. Memory Care Supervision Audit

A Memory Care Supervision Audit Tool implemented to monitor:

Staffing coverage

Resident supervision

Adherence to support plans

Timely response to behaviors

Audit Schedule

42b - Abuse (continued)

Daily for 14 days

Weekly for 30 days

Monthly for 3 months

Quarterly ongoing

Responsible Party

Executive Director or Designee

B. Corrective Action for Non-Compliance

Any staffing or supervision failures will result in:

Immediate correction

Staff counseling

Retraining

Progressive discipline if repeated
Date of Full Compliance

Expected Date of Compliance: 02/15/2026
Audit Schedule

Daily × 14 days

Weekly × 30 days

Monthly × 3 months

Quarterly ongoing

Responsible: Executive Director / Wellness Director/Designee

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented [redacted] - 04/13/2026)

42c - Treatment of Residents

4. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

42c - Treatment of Residents *(continued)*

Description of Violation

On [redacted] at approximately 11:45 am, staff person D went into resident [redacted]s room to take a lunch order and provide care. Resident [redacted] had a bowel movement, and staff person D proceeded to complete care. According to resident [redacted]s support plan, the resident needs the assistance of one person to complete a bowel movement. Resident [redacted] is able to communicate with staff and move side to side to complete care. Resident [redacted] stated that staff person D was rough through the changes, and when asked, staff person D, in a harsh tone of voice, stated, "This is how I was taught to do it." After that encounter, resident [redacted] felt uncomfortable and was afraid that the care manager would hit them.

Repeat Violation [redacted]

Plan of Correction ***Accept [redacted] - 02/06/2026)***

PLAN OF CORRECTION

Tag: Resident Rights / Dignity / Abuse Prevention / Proper Care Delivery
Citation Date: 11/17/25
Time Observed: Approximately 11:45 a.m.
Repeat Violation Date: 07/02/25
Regulatory Authority: 55 Pa. Code §2600.186, §2600.15, §2600.190

1. Immediate Corrective Action (Completed)

Resident [redacted] was immediately assessed by nursing leadership to ensure safety, comfort, and emotional well-being.

Resident [redacted] was reassured, their concerns were acknowledged, and they were informed they would not receive care from staff person D pending review.

Staff person D was immediately suspended from duties pending investigation.

The incident was reviewed by the Executive Director and Director of Wellness.

Immediate corrective action completed by: Executive Director / Director of Wellness

Date of completion: 11/17/25

2. Protection of Residents During Correction

Resident [redacted] was reassigned to alternate caregivers.

Increased supervisory oversight was implemented for all care provided to Resident [redacted]

Resident [redacted]s representative was notified as appropriate.

3. Root Cause Analysis

42c - Treatment of Residents (continued)

The investigation determined that:

Staff person D demonstrated inappropriate care technique and tone, inconsistent with resident dignity and rights.

There was a training gap related to:

Respectful communication

The repeat nature of the violation indicates the need for competency-based retraining and ongoing observation, not retraining alone.

4. Corrective Actions to Prevent Recurrence
A. Individual Staff Corrective Action

Staff person D completed:

One-on-one counseling

Mandatory retraining

Return demonstration of personal care skills

Staff person D may not resume unsupervised care until competency is validated.

Responsible Party: Director of Wellness

Completion Date: 11/22/25

B. Support Plan Review

Resident ██s support plan was reviewed with care staff to reinforce:

Required level of assistance

Resident communication preferences

Responsible Party: Director of Wellness

Completion Date: 11/20/25

5. Mandatory Staff Training (Corrective Training)
Training Title

Resident Rights, Dignity in Care & Gentle Personal Care Techniques

42c - Treatment of Residents (continued)

Training Content Includes
1. Resident Rights & Dignity (§2600.186)

Freedom from abuse, neglect, and intimidation

Emotional and psychological safety

Right to respectful, gentle care

2. Appropriate Personal Care Techniques

Safe and gentle bowel care

Proper body mechanics

Using resident participation appropriately

Avoiding rough or hurried care

3. Communication & Tone

Respectful language

Trauma-informed communication

Responding to resident feedback appropriately

4. Abuse Prevention & Recognition

Physical vs emotional abuse

How tone and technique can constitute abuse

Mandatory reporting responsibilities

5. Staff Accountability

“This is how I was taught” is not acceptable

Following policies and support plans

Consequences of non-compliance

Staff Required to Attend

42c Treatment of Residents (continued)

All direct care staff

Med Techs

Supervisors

Training Format

Instructor led in service

Demonstration and return demonstration

Written acknowledgment

Training Completion Timeline

Initial training completed by: 02/15/2026

New hires trained during orientation

Annual refresher required

Responsible Party

Executive Director / Director of Wellness/Designee

6. Monitoring & Quality Assurance
A. Direct Care Observation Audit

A Personal Care Observation Audit Tool has been implemented to observe:

Care techniques

Tone and communication

Adherence to support plans

Resident comfort and response

Audit Schedule

Daily observations for 14 days

Weekly observations for 30 days

42c - Treatment of Residents (continued)

Monthly observations for 3 months

Quarterly ongoing

Responsible Party

Director of Wellness or Designee
B. Corrective Action for Non-Compliance

Any observed rough care or inappropriate communication will result in:

Immediate intervention

Removal from care

Retraining

Progressive discipline up to termination
Date of Full Compliance

Expected Date of Compliance: 02/15/2026
Observation Schedule

Daily × 14 days

Weekly × 30 days

Monthly × 3 months

Quarterly ongoing

Responsible: Director of Wellness / Designee

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented [redacted] - 04/13/2026)

63a - First Aid/CPR Training

5. 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] and [redacted], from 7:00 pm to 7:00 am, 68 residents were present in the home. During this time only one staff person was present in the home who was

63a - First Aid/CPR Training (continued)

certified in first aid, obstructed airway techniques and CPR.

Plan of Correction ***Accept █ - 02/06/2026)***

PLAN OF CORRECTION

Tag: First Aid / CPR / Obstructed Airway Coverage
Citation Dates: 11/15/25, 11/17/25, 11/24/25
Timeframe: 7:00 p.m. – 7:00 a.m.
Census: 68 residents
Regulatory Authority: 55 Pa. Code §2600.13, §2600.190

1. Immediate Corrective Action (Completed)

Upon identification of the deficiency, the overnight schedule was immediately corrected to ensure that a minimum of two staff members certified in First Aid, CPR, and Obstructed Airway techniques are scheduled and on duty at all times.

Verification of current certifications for all overnight staff was completed.

Any staff without current certification were removed from being counted toward coverage until training was completed.

Immediate corrective action completed by: Executive Director / Scheduler

Date of completion: 11/25/25

2. Protection of Residents During Correction

Residents were protected immediately by ensuring continuous emergency-trained staff coverage on all overnight shifts.

On-call leadership was notified and remains available to respond to emergencies.

No overnight shift is permitted to operate without required certification coverage.

3. Root Cause Analysis

The investigation determined that:

Scheduling practices did not consistently verify certification coverage across shifts, particularly overnight.

Certification status was tracked but not actively cross-checked against daily schedules.

The repeat occurrence across multiple dates indicates a systemic scheduling and oversight failure, not isolated error.

4. Corrective Actions to Prevent Recurrence

63a - First Aid/CPR Training (continued)

A. Staffing & Scheduling Controls

Overnight staffing requirements have been revised to ensure:

A minimum of two CPR/First Aid/Obstructed Airway-certified staff are on duty at all times when census exceeds 50 residents.

Schedules must now include a certification verification check prior to final approval.

Responsible Party: Executive Director / Scheduler / Designee

Completion Date: 01/08/2026

B. Certification Tracking System

A Certification Tracking Log has been implemented and includes:

Certification type

Expiration dates

Shift eligibility

Staff with expired certifications are not permitted to work unsupervised shifts.

Responsible Party: HR / Executive Director

Completion Date: 11/26/25

5. Mandatory Staff Training (Corrective Training)
Training Title

First Aid, CPR & Obstructed Airway Emergency Response

Training Content Includes

Adult CPR

Obstructed airway / choking response

Emergency response protocols

When to call 911

Staff roles during emergencies

63a First Aid/CPR Training (continued)

Documentation and post incident reporting

Overnight emergency response scenarios

Staff Required to Attend

All direct care staff

All overnight staff

Supervisors

Training Format

Instructor led certification course

Hands on skills demonstration

Certification validation

Training Completion Timeline

All overnight staff certified by: 01/08/2026

Recertification completed prior to expiration

Responsible Party

Executive Director / HR / Director of Wellness

6. Monitoring & Quality Assurance
A. CPR Coverage Audit Tool

A CPR Coverage Audit Tool has been implemented to verify:

Certified staff on each shift

Certification validity

Compliance with staffing requirements

Audit Schedule

Daily schedule review for 30 days

63a - First Aid/CPR Training (continued)

Weekly audits for 3 months

Monthly audits ongoing

Responsible Party

Executive Director/ Director of Wellness/ Designee

B. Corrective Action for Non-Compliance

Any shift identified without required certification coverage will result in:

Immediate correction

Schedule revision

Leadership review

Disciplinary action if repeated
Date of Full Compliance

Expected Date of Compliance: 2/15/2026

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented ███ - 04/13/2026)

66b - Training Plan Content

6. 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.

Description of Violation

The home's staff training plan does not include the required training courses for each staff person or the dates, times, and locations of the scheduled training for each staff person for the upcoming year.

Plan of Correction ***Accept ███ - 02/06/2026)***

PLAN OF CORRECTION

Tag: Staff Training Plan – Annual Training Schedule
Regulatory Authority: 55 Pa. Code §2600.65
Deficiency: Staff training plan does not include required courses for each staff person or scheduled dates, times, and locations for the upcoming year.

66b - Training Plan Content (continued)

1. Immediate Corrective Action 1/02/2026

The existing staff training plan was immediately removed from use.

A new Annual Staff Training Plan template was developed to include:

Required training courses by staff role

Scheduled dates, times, and locations

Responsible trainer

Leadership reviewed regulatory training requirements to ensure all required courses were included.

Immediate corrective action completed by: Executive Director / HR

Date of completion: 1/2/2026

2. Root Cause Analysis

The investigation determined that:

The prior training plan was generic and incomplete, lacking role-specific requirements.

There was no standardized process for annual training planning and scheduling.

Training oversight was not assigned to a single accountable role.

This resulted in non-compliance with documentation requirements, not a lack of training delivery.

3. Corrective Actions to Prevent Recurrence
A. Development of a Comprehensive Annual Training Plan

A 12-month Annual Staff Training Plan has been created that includes:

All required PA 2600 training topics

Role-specific training requirements

Scheduled dates, times, and locations

Trainer/instructor identified

The plan applies to:

66b - Training Plan Content (continued)

Direct care staff

Med Techs

Nurses

Supervisors

Administrative staff

Responsible Party: Executive Director / HR

Completion Date: 01/02/2026

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented [redacted] - 04/13/2026)

91 - Telephone Numbers

7. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

The incorrect telephone number for the personal care home complaint hotline was posted on or by the telephone in room [redacted] and room [redacted]

Plan of Correction ***Accept [redacted] - 02/06/2026)***

PLAN OF CORRECTION

Tag: Resident Rights – Access to Complaint Hotline
Regulatory Authority: 55 Pa. Code §2600.42, §2600.44, §2600.190
Deficiency: Incorrect telephone number for the Personal Care Home Complaint Hotline was posted on or by the telephone in Room [redacted] and Room [redacted]

1. Immediate Corrective Action on 12/18/2025

The incorrect complaint hotline postings in Room [redacted] and Room [redacted] were immediately removed.

Correct signage with the accurate Pennsylvania Personal Care Home Complaint Hotline number was posted in both rooms.

91 - Telephone Numbers (continued)

A facility-wide check was conducted to ensure all posted hotline numbers throughout the home were accurate.

Immediate corrective action completed by: Executive Director / Maintenance Director

Date of completion: 12/18/2025

2. Protection of Residents During Correction

Residents were ensured immediate access to the correct complaint hotline information.

No residents were restricted from making complaints during the correction process.

Residents were verbally informed that the correct hotline number is posted and available.

3. Root Cause Analysis

The investigation determined that:

There was no standardized verification process for regulatory postings.

Signage updates were completed without a secondary accuracy review.

Responsibility for regulatory postings was not clearly assigned, creating a risk for outdated or incorrect information.

B. Facility-Wide Verification Process

A Regulatory Posting Audit Tool has been implemented to verify:

Correct hotline number

Proper placement by telephones

Legibility and accessibility

Responsible Party: Executive Director / Designee

Completion Date: 02/15/2026
Audit Schedule

Weekly × 30 days

Monthly × 3 months

Quarterly ongoing

91 - Telephone Numbers (continued)

Responsible: Executive Director / Designee

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented (- 04/13/2026)

100b - Removal Snow/Obstructions

8. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On , at approximately 10:34 am, there was an approximate 1-inch accumulation of snow on the exterior walkway outside of the emergency exit located near room

Plan of Correction ***Accept (- 02/06/2026)***

PLAN OF CORRECTION

Tag: Environmental Safety – Snow & Ice Removal
Citation Date: 12/15/25
Time Observed: Approximately 10:34 a.m.
Location: Exterior emergency exit walkway near Room
Regulatory Authority: 55 Pa. Code §2600.81, §2600.190

1. Immediate Corrective Action Corrected onsite 12/15/2025

The exterior walkway near the emergency exit by Room was immediately cleared of snow.

Ice melt was applied to the affected area to prevent refreezing.

The walkway was visually inspected to ensure it was safe, passable, and free of hazards.

Immediate corrective action completed by: Maintenance Director / Executive Director

Date of completion: 12/15/25

2. Protection of Residents During Correction

Residents and staff were restricted from using the affected exit until snow removal was completed.

Alternate exits remained accessible and clear during the correction.

No injuries were reported related to this condition.

100b - Removal Snow/Obstructions (continued)

3. Root Cause Analysis

The investigation determined that:

Snow accumulation occurred due to weather conditions and delayed inspection of emergency exit pathways.

There was no formalized, documented schedule for exterior checks during active snow events.

Responsibility for snow monitoring was not clearly assigned during daytime hours.

4. Corrective Actions to Prevent Recurrence
A. Winter Weather Response Plan Implementation

A Winter Weather Response Plan has been implemented requiring:

Priority snow and ice removal for all emergency exits and exit pathways

Scheduled exterior checks during snow events

Responsible Party: Maintenance Director

Completion Date: 12/18/25

B. Exterior Safety Inspection Schedule

Exterior emergency exit walkways will be inspected:

Every 4 hours during snow or ice events

Daily during winter months, regardless of weather

Findings will be documented.

Responsible Party: Maintenance Director / Designee

Completion Date: 12/18/25

5. Mandatory Staff Training (Corrective Training)
Training Title

Environmental Safety & Winter Weather Hazard Prevention

Training Content Includes

Maintaining safe egress routes (§2600.81)

100b - Removal Snow/Obstructions (continued)

Importance of clear emergency exits

Snow and ice hazard recognition

Staff responsibility to report hazards immediately

Proper use of ice melt and signage

Emergency response during inclement weather

Staff Required to Attend

Maintenance staff

Supervisors

On-duty leadership

Any staff assigned environmental rounds

Training Format

Instructor-led in-service

Review of Winter Weather Response Plan

Written acknowledgment of understanding

Training Completion Timeline

Initial training completed by: 01/15/2026

New hires trained during orientation

Responsible Party

Executive Director / Maintenance Director
Corrective Action for Non-Compliance

Any identified snow or ice accumulation will result in:

Immediate removal

100b - Removal Snow/Obstructions (continued)

Documentation

Staff counseling if repeated
Date of Full Compliance
Expected Date of Compliance: 02/15/2026
Audit Frequency

Every 4 hours during snow/ice events

Daily during winter months

Responsible: Maintenance Director / Designee

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented - 04/13/2026)

107a - Emergency Preparedness

9. Requirements

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

Staff person E, the administrator does not have the emergency preparedness plan for the local municipality.

Plan of Correction ***Accept (- 02/06/2026)***

Corrected on site. The plan was there, just not in the correct location. Showed to the Surveyor on site

Licensee's Proposed Overall Completion Date: *02/03/2026*

Implemented - 04/13/2026)

132h - Designated Meeting Place

10. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drills on at 1:20 pm, at 7:10 pm, at 1:48 pm, at 3:37 pm, at 11:49 pm, at 10:52 am, at 8:42 pm, and at 11:35 am, all residents of the home did not evacuate to a designated meeting place away from the building or within the fire-safe area. Resident reported that has been bed bound since April 2025 and has not participated in fire drills.

Plan of Correction ***Accept - 02/06/2026)***

PLAN OF CORRECTION

132h - Designated Meeting Place (continued)

Tag: Fire Drills – Resident Participation / Bed-Bound Resident
Resident:
Regulatory Authority: 55 Pa. Code §2600.27, §2600.186, §2600.190

1. Immediate Corrective Action 12/15/2025

Resident s status as bed-bound since April 2025 was immediately reviewed by the Director of Wellness.

A resident-specific fire evacuation plan was developed for Resident to ensure inclusion in all future fire drills.

Staff were immediately instructed that bed-bound residents must still be included in fire drills through:

Movement to a designated fire-safe area,

Immediate corrective action completed by: Executive Director / Director of Wellness

Date of completion: 12/15/2025

Resident s safety, dignity, and comfort are maintained during all drills.

Resident will no longer be excluded from fire drills.

3. Root Cause Analysis

The investigation determined that:

Staff misunderstood how to include bed-bound residents in fire drills.

There was no individualized evacuation plan documented for Resident

Fire drill participation was incorrectly interpreted as requiring full building evacuation only.

This resulted in unintentional exclusion, not willful non-compliance.

4. Corrective Actions to Prevent Recurrence

B. Fire Drill Procedure Clarification

Fire drill procedures were clarified to state:

All residents must be included in drills

Bed-bound residents may participate via fire-safe area placement or simulation

Responsible Party: Executive Director

132h - Designated Meeting Place (continued)

Completion Date: 02/15/2026

5. Mandatory Staff Training (Corrective Training)
Training Title

Fire Drill Participation for Non-Ambulatory & Bed-Bound Residents

Training Content Includes

Fire drill requirements under PA 2600 (§2600.27)

Definition and use of fire-safe areas

Proper inclusion of bed-bound residents

Staff assignment and accountability during drills

Documentation of resident participation

Resident rights and dignity during emergency preparedness activities

Staff Required to Attend

Direct care staff

Nurses

Supervisors

Maintenance staff

On-duty leadership
Training Format

Instructor-led in-service

Walk-through of fire-safe areas

Review of Resident ██s evacuation plan (without identifying information)

Written acknowledgment

Training Completion Timeline

132h - Designated Meeting Place (continued)

Initial training completed by: [insert date within 14–21 days]

New hires trained during orientation

Annual refresher required

Responsible Party

Executive Director / Director of Wellness / Maintenance Director
Date of Full Compliance

Expected Date of Compliance: 02/15/2026

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented [redacted] - 04/13/2026)

141b1 - Annual Medical Evaluation

11. Requirements

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

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted] The resident's previous medical evaluation was completed on [redacted]

Resident [redacted]s most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted]

Resident [redacted]s most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted]

Repeat Violation [redacted] et al, [redacted]

Plan of Correction ***Directed ([redacted] - 02/09/2026)***

I am respectfully requesting removal of the cited deficiency related to resident medical evaluations, which has been identified as a repeat violation.

The citation references the following residents:

Resident [redacted]
Most recent medical evaluation completed on 05/05/25

141b1 - Annual Medical Evaluation (continued)

Previous medical evaluation completed on 05/13/23

Resident █
Most recent medical evaluation completed on 11/17/25
Previous medical evaluation completed on 11/22/23

Resident █
Most recent medical evaluation completed on 01/09/25
Previous medical evaluation completed on 09/18/23

This issue was previously addressed and corrected during an earlier survey cycle, as reflected by the most recent medical evaluations completed for each resident. Corrective actions implemented at that time ensured that all current and future medical evaluations are completed in accordance with regulatory requirements.

Because medical evaluations are historical clinical documents, the home is unable to retroactively create or replace documentation that did not exist at the time without compromising the integrity of the medical record. As part of our corrective actions, addendums were added to all applicable resident charts to clearly document compliance and continuity of care moving forward.

The home has demonstrated sustained compliance through:

Completion of all required current medical evaluations

Addition of chart addendums to address historical gaps

Implementation of systemic processes to prevent recurrence

Ongoing monitoring to ensure timely completion of evaluations going forward

Given that this concern was already corrected, and that historical documentation cannot be recreated, we respectfully request that this citation be removed from the survey findings.

Please let me know if any additional clarification is needed. Thank you for your time and consideration.

Proposed Overall Completion Date: 04/15/2026

Directed
By 2/28/26: The administrator or designated staff person will review all resident records to ensure an in-person medical evaluation has been completed for all residents within the past year and the medical evaluation is completed accurately and in its entirety including all required information. Any residents with out of date medical evaluations will be scheduled for an in-person appointment with the physician. Documentation of record review will be kept. All staff persons involved with the medical evaluation process will be educated on the required contents of the medical evaluation form and the authorized persons (a physician, physician's assistant or certified registered nurse practitioner) who are permitted to complete a medical evaluation form. This will include when the medical evaluation form is incomplete or incorrect the medical evaluation will be corrected by the person who completed

141b1 - Annual Medical Evaluation (continued)

the medical evaluation or an RN or LPN will contact the person who completed the medical evaluation, obtain permission to correct the medical evaluation form and will document the date, time and the person spoken to on the form next to the correction. Documentation of education shall be kept.

Directed Completion Date: *02/28/2026*

Implemented - 04/13/2026)

162c - Menus Posted

12. Requirements

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

Description of Violation

The home's menu for the week of was posted. However, the menu for the current was not posted in a conspicuous and public place in the home.

Repeat Violation:

Plan of Correction ***Accept - 02/06/2026)***

PLAN OF CORRECTION

Tag: Menu Posting / Resident Rights / Nutrition Services
Deficiency: The current menu was not posted in a conspicuous and public place in the home.
Repeat Violation Date: 07/09/25
Regulatory Authority: 55 Pa. Code §2600.181, §2600.42, §2600.190

1. Immediate Corrective Action 12/15/2025

The current weekly menu was immediately printed and posted in conspicuous and public locations within the home, including:

Main lobby / common area

Dining room

Outdated menus (9/9/25–11/29/25) were removed to prevent confusion.

Immediate corrective action completed by: Executive Director / Dietary Manager

Date of completion: 12/15/2025

2. Protection of Residents During Correction

Residents were immediately provided access to the current menu so they could:

162c - Menus Posted (continued)

Know daily meal options

Make informed meal choices

Dietary staff verbally confirmed daily meal options with residents during service until posting was verified.

3. Root Cause Analysis

The investigation determined that:

Menu posting responsibilities were not clearly assigned.

There was no verification process to ensure the current menu replaced outdated menus weekly.

The repeat nature of the citation indicates a system failure in menu management, not an isolated oversight.

4. Corrective Actions to Prevent Recurrence
A. Menu Posting Procedure Implementation

A standardized Menu Posting Procedure has been implemented requiring:

The current weekly menu to be posted every Sunday prior to the new week

Removal of all outdated menus

Posting in designated public areas

Responsible Party: Dietary Manager

Completion Date: 02/15/2026
B. Designation of Responsibility

The Dietary Manager is now responsible for:

Printing the current menu

Posting and removing menus

Verifying postings weekly

Backup designee assigned during absences.

5. Mandatory Staff Training (Corrective Training)
Training Title

162c Menus Posted (continued)

Menu Posting, Resident Rights & Nutrition Transparency

Training Content Includes

Resident rights related to food service (§2600.42)

Requirement to post the current menu (§2600.181)

Importance of conspicuous and public posting

Weekly menu posting process

Staff responsibility to report missing or outdated menus

Staff Required to Attend

Dietary staff

Supervisors

Administrative staff involved in postings
Training Completion Timeline

Initial training completed by: 02/15/2026

New hires trained during orientation
Audit Schedule

Weekly audits for 30 days

Monthly audits for 3 months

Quarterly audits ongoing
Date of Full Compliance

Expected Date of Compliance: 02/15/2026
Audit Schedule

Weekly × 30 days

Monthly × 3 months

Quarterly ongoing
Responsible: Dining Director / Designee

Licensee's Proposed Overall Completion Date: *02/15/2026*

162c - Menus Posted *(continued)*

Implemented - 04/13/2026)

183e - Storing Medications

13. 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 is prescribed to be taken by mouth every 4 hours as needed. On , at approximately 12:35 pm, during the medication cart audit a puncture was observed on the back of the bubble pack at spot #9 the pill remained in the pack.

Resident is prescribed take 1 tablet by mouth twice a day and 1 tablet every 6 hours as needed. On , at approximately 12:45 pm, during the medication cart audit a puncture was observed on the back of the bubble pack at spot #9 the pill remained in the pack.

Plan of Correction ***Accept - 02/06/2026)***

PLAN OF CORRECTION

Tag: Medication Administration / Medication Integrity / Proper Storage
Residents Involved: and
Citation Date: 12/16/25
Times Observed:

12:35 p.m. – Resident ( )

12:45 p.m. – Resident (Alprazolam 0.5 mg scheduled & PRN)

Regulatory Authority: 55 Pa. Code §2600.181, §2600.187, §2600.190

1. Immediate Corrective Action 12/15/2025

The punctured bubble packs for Resident ( ) and Resident ( ) were immediately removed from the medication cart.

Medication that was exposed was wasted and disposed of appropriately

The medication carts were inspected in full to ensure no additional punctured or compromised packaging was present.

Immediate corrective action completed by: Director of Wellness / Designee

Date of completion: 12/16/25

183e - Storing Medications (continued)

2. Protection of Residents During Correction

Both residents continued to receive medications without interruption using properly packaged medications.

No medication doses were missed or administered from compromised packaging.

Nursing leadership confirmed MAR accuracy and medication availability.

3. Root Cause Analysis

The investigation determined that:

Bubble packs were likely punctured due to improper handling and storage within the medication cart.

Staff required reinforcement on:

Proper removal techniques from bubble packs

Prohibition against puncturing medication packs

Extra safeguards for anti-anxiety / controlled medications

There was no standardized process requiring visual inspection of bubble packs prior to and after medication passes.

4. Corrective Actions to Prevent Recurrence
A. Medication Handling & Storage Reinforcement

Medication handling procedures were reinforced to clarify:

Pills must be removed only through the designated foil backing

Puncturing or altering packaging is prohibited

Compromised medication packaging must be removed immediately

Responsible Party: Director of Wellness

Completion Date: 12/20/25

B. Controlled Medication Safeguards

Anti-anxiety medications (e.g., [redacted]) are now:

Flagged for extra inspection during audits

183e Storing Medications (continued)

Reviewed for integrity during each cart check

Responsible Party: Director of Wellness

Completion Date: 12/20/25

5. Mandatory Staff Training (Corrective Training)
Training Title

Medication Integrity, Proper Bubble Pack Handling & Controlled Medications

Training Content Includes

Proper medication administration procedures (§2600.187)

Correct technique for removing medications from bubble packs

Prohibition against puncturing or altering medication packaging

Handling of PRN medications

Controlled medication awareness (benzodiazepines)

Identifying compromised packaging

Required actions when compromised medication is discovered

Documentation and reporting requirements

Staff Required to Attend

All medication technicians

Nurses

Supervisors

Agency staff authorized to pass medications

Training Format

Instructor led in service

Written acknowledgment

183e - Storing Medications (continued)

Training Completion Timeline

Initial training completed by: 02/15/2026

New hires trained during orientation

Annual refresher required

Responsible Party

Director of Wellness/Designee
Medication Cart & Bubble Pack Audit Tool
Corrective Action for Non-Compliance

Any compromised packaging identified will result in:

Immediate removal of medication

Staff counseling

Retraining

Progressive discipline if repeated

A Medication Integrity Audit Tool has been implemented to verify:

Bubble packs intact

No punctures or damage

Proper storage and handling

MAR accuracy

Audit Schedule

Daily cart checks for 14 days

Weekly audits for 30 days

Monthly audits for 3 months

Quarterly ongoing
Date of Full Compliance

183e - Storing Medications (continued)

Expected Date of Compliance: 02/15/2026
Audit Schedule

Daily × 14 days

Weekly × 30 days

Monthly × 3 months

Quarterly ongoing

Responsible: Director of Wellness / Designee

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented (- 04/13/2026)

184a - Resident's Meds Labeled

14. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for resident tab, "take one tablet by mouth every 8 hours as needed for pain," does not match the medication administration record. The medication did not have a direction change sticker.

Plan of Correction ***Accept (- 02/06/2026)***

PLAN OF CORRECTION

Tag: Medication Administration Record (MAR) Accuracy / Pharmacy Labeling
Resident:
Medication: tablet
Deficiency: Pharmacy label directions did not match the MAR, and no direction-change sticker was present.
Regulatory Authority: 55 Pa. Code §2600.187, §2600.190

1. Immediate Corrective Action 12/15/2025

Upon discovery, administration of Resident s Acetaminophen was held until verification was completed.

184a - Resident's Meds Labeled (continued)

The MAR and pharmacy label were immediately reconciled with the physician's order.

The pharmacy was contacted, and a corrected label with proper directions was obtained.

A direction-change sticker was applied as required.

The MAR was reviewed and confirmed to accurately reflect the current physician order.

Immediate corrective action completed by: Director of Wellness / Designee

Date of completion: 12/15/2025

2. Protection of the Resident During Correction

Resident ██ did not receive any medication doses from mismatched or unclear directions.

Pain management needs were assessed, and medication was resumed only after correct labeling and MAR alignment were verified.

No adverse effects were identified.

3. Root Cause Analysis

The investigation determined that:

There was insufficient verification between the pharmacy label and the MAR upon receipt of medication.

Staff required reinforcement on:

Identifying MAR–label discrepancies

Required use of direction-change stickers

There was no standardized double-check process when PRN medications were reordered or updated.

This was a process oversight, not intentional non-compliance.

4. Corrective Actions to Prevent Recurrence
A. MAR & Label Reconciliation Process

A standardized Medication Reconciliation Process has been implemented requiring:

Verification that pharmacy labels match the MAR before medication is placed into service

Immediate correction and pharmacy notification for discrepancies

184a Resident's Meds Labeled (continued)

Responsible Party: Director of Wellness

Completion Date: 02/15/2026

B. Pharmacy Coordination

Pharmacy procedures were reviewed to ensure:

All direction changes include a direction change sticker

Updated labels are provided promptly

Responsible Party: Executive Director / Director of Wellness

Completion Date: 12/15/2025

5. Mandatory Staff Training (Corrective Training)
Training Title

Medication Transcription, MAR Accuracy & Label Verification

Training Content Includes

Importance of MAR accuracy (§2600.187)

Matching physician orders, MARs, and pharmacy labels

Identifying and responding to discrepancies

Direction change stickers: when and how to use them

PRN medication order verification

Documentation and escalation requirements

Staff Required to Attend

Medication technicians

Nurses

Supervisors

Agency staff authorized to administer medications

184a Resident's Meds Labeled (continued)

Training Format

Instructor led in service

Written acknowledgment

Training Completion Timeline

Initial training completed by: 02/15/2026

New hires trained during orientation

Annual refresher required

Responsible Party

Director of Wellness / Designee
Audit Schedule

Daily audits for 14 days

Weekly audits for 30 days

Monthly audits for 3 months

Quarterly ongoing
Corrective Action for Non Compliance

Any discrepancy identified will result in:

Immediate medication hold if needed

Pharmacy notification

Staff counseling and retraining

Incident reporting if indicated
Date of Full Compliance

Expected Date of Compliance: 02/15/2026

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented 04/13/2026)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted], take one tablet by mouth daily. However, this medication was not administered to resident [redacted] since [redacted] because the medication was not available in the home.

Resident [redacted] is prescribed [redacted], take one tablet by mouth twice a day at 9:00 am and 6:00 pm. However, resident [redacted] was administered [redacted] on [redacted] at 10:15 am.

Resident [redacted] is prescribed [redacted] take one tablet by mouth twice a day at 9:00 am and 6:00 pm. However, this medication was not administered to resident [redacted] on [redacted] at 6:00 pm. The medication was initialed as administered.

Repeat Violation [redacted]

Plan of Correction ***Accept [redacted] - 02/06/2026)***

PLAN OF CORRECTION

Tag: Medication Administration / Availability / MAR Accuracy
Residents Involved: [redacted] and [redacted]
Repeat Violation Dates: 03/30/25, 07/09/25
Current Findings Date: 12/11/25
Regulatory Authority: 55 Pa. Code §2600.187, §2600.190

1. IMMEDIATE CORRECTIVE ACTION 12/15/2025
Resident [redacted] – Medication Availability

Upon discovery that [redacted] was unavailable and not administered since 12/11/25, the pharmacy was contacted immediately.

Medication was delivered and placed into service.

MAR was reviewed and updated to reflect missed doses accurately.

Resident [redacted] was assessed for any adverse effects related to missed doses.

Immediate corrective action completed by: Director of Wellness

Date completed: 12/15/2025

Resident [redacted] – Medication Timing & Documentation

187d - Follow Prescriber's Orders (continued)

Administration of [redacted] was immediately reviewed.

Incorrect administration time (10:15 am instead of 9:00 am) was addressed.

The missed 6:00 pm dose on 12/11/25 was identified as documented incorrectly as administered.

MAR documentation was corrected per policy, and nursing leadership was notified.

Resident [redacted] was assessed for adverse effects related to timing error and missed dose.

Immediate corrective action completed by: Director of Wellness / Executive Director

Date completed: 12/15/2025

2. PROTECTION OF RESIDENTS DURING CORRECTION

Both residents were medically assessed and monitored.

No adverse outcomes were identified.

Medications were resumed and administered exactly as prescribed.

Physicians were notified as appropriate.

Residents' safety and medication continuity were restored immediately.

3. ROOT CAUSE ANALYSIS

The investigation determined that:

There was insufficient verification of medication availability prior to depletion.

PRN and scheduled benzodiazepines required heightened oversight.

Staff failed to:

Administer medication at the prescribed time

Accurately document medication administration

There was no consistent double-check process for:

Medication stock

High-risk medications

187d - Follow Prescriber's Orders (continued)

End-of-shift MAR reconciliation

Repeat violations indicate a systemic medication management breakdown, not isolated error.

4. CORRECTIVE ACTIONS TO PREVENT RECURRENCE
A. Medication Availability Controls

A Medication Inventory & Refill Tracking Process has been implemented to ensure:

Medications are reordered before depletion

Backup supply verification

Responsible Party: Director of Wellness

Completion Date: 02/15/2026

B. Medication Timing & Administration Accuracy

Administration times must match MAR exactly.

Late or missed doses must be:

Documented accurately

Reported to nursing leadership

Physician notified as indicated

Responsible Party: Director of Wellness

Completion Date: 02/15/2026

C. MAR Documentation Reinforcement

Staff re-educated that:

Medications may never be initialed unless administered

Documentation errors constitute a medication error

End-of-shift MAR reconciliation is now required.

Responsible Party: Executive Director / DOW

187d - Follow Prescriber's Orders (continued)

Completion Date: 02/15/2026

5. MANDATORY STAFF TRAINING (CORRECTIVE TRAINING)
Training Title

Medication Administration Accuracy, Documentation & Availability

Training Content Includes

Proper medication administration (§2600.187)

Administering medications at scheduled times

Medication availability & reorder responsibilities

MAR accuracy and legal documentation standards

Handling missed, late, or unavailable medications

Controlled medication safeguards (benzodiazepines)

Prohibition against falsifying documentation

Reporting and escalation requirements

Staff Required to Attend

Medication Technicians

Nurses

Supervisors

Agency staff authorized to pass medications

Training Format

Instructor-led in-service

Return-demonstration competency

Written acknowledgment

Training Completion Timeline

187d - Follow Prescriber's Orders (continued)

Initial training completed by: 02/15/2026

New hires trained prior to independent med pass

Annual refresher required

Responsible Party
Director of Wellness / Designee

6. MONITORING & QUALITY ASSURANCE
A. Medication Administration Audit Tool

A Medication Administration Accuracy Audit Tool has been implemented to monitor:

Correct medication

Correct time

Accurate MAR documentation

Medication availability

Audit Schedule

Daily audits for 14 days

Weekly audits for 30 days

Monthly audits for 3 months

Quarterly ongoing

B. Corrective Action for Non-Compliance

Any future errors will result in:

Immediate resident assessment

Staff counseling

Retraining

Progressive discipline

187d - Follow Prescriber's Orders (continued)

Incident reporting as required

7. MAINTENANCE OF COMPLIANCE

Medication compliance reviewed during:

Nursing meetings

8. RESPONSIBLE PARTIES SUMMARY
Task Responsible Party
Medication availability tracking Director of Wellness
Staff training Director of Wellness / Designee
MAR audits DOW / Designee
9. DATE OF FULL COMPLIANCE

Expected Date of Compliance: 02/15/2026

Licensee's Proposed Overall Completion Date: *02/15/2026*

Implemented [redacted] - 04/13/2026)