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

April 14, 2026

[redacted]
THE COMMUNITY AT ROCKHILL
[redacted]

RE: THE COMMUNITY AT ROCKHILL
3250 STATE ROAD
SELLERSVILLE, PA, 18960
LICENSE/COC#: 12687

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE COMMUNITY AT ROCKHILL* **License #**: *12687* **License Expiration**: *04/02/2026*

Address: *3250 STATE ROAD, SELLERSVILLE, PA 18960*

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

Administrator

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

Legal Entity

Name: *THE COMMUNITY AT ROCKHILL*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/01/2012* **Issued By**: *West Rockhill Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *47* **Waking Staff**: *35*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/16/2025*

Inspection Dates and Department Representative

12/16/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served**: *47*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*

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

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

Inspections / Reviews

12/16/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/22/2026*

01/28/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/20/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/02/2026*

Inspections / Reviews *(continued)*

02/04/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/20/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/20/2026*

04/14/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/20/2026*

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

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person A does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Directed [redacted] - 02/04/2026)***

See attached.
The staff person submitted transcripts from [redacted] high school to verify completion. Administrator will review in QA meeting the importance of having required documentation prior to the staff member coming to the floor.
1/30/2026
Staff person was removed from schedule to receive transcript. Transcript was received on 1/22/2026. The staff person returned on 1/23/2026.
Audit will be done of all new hires for compliance and PCHA/designee will review.

Proposed Overall Completion Date: 02/01/2026

Directed Plan of Correction [redacted] 2/4/26):

In addition to, and to clarify the above plan of correction, starting immediately, the administrator or designee shall audit all new hire credentials prior to the employee providing unsupervised direct care duties. Documentation of audits shall be kept.

Directed Completion Date: *02/01/2026*

Implemented [redacted] - 04/14/2026)

63a - First Aid/CPR Training

2. Requirements

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

Description of Violation

On [redacted] from 11 PM till 7:15 AM next day, 45 residents were present in the home. During this time, there was no staff person present in the home who was certified in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction ***Accept ([redacted] - 02/04/2026)***

Audit of all the staff currently trained will be reviewed and PCHA/designee will review the schedule to ensure that a staff person is certified in CPR shall be present in the home during all shifts. PHCA/ designee will conduct audit of all staff members currently certified in CPR. Results of audit will be reviewed at QAPI.
1/30/2026
Audit completed on 1/20/2026. PCHA/designee will monitor compliance. PCHA/designee will review the weekly

63a - First Aid/CPR Training (continued)

schedule X4 weeks then monthly X2months to ensure all staff are CPR trained.

Licensee's Proposed Overall Completion Date: *02/01/2026*

Implemented [redacted] - 04/14/2026)

64c - Annual Training

3. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person B, the home's administrator, completed only 22 hours of Department-approved training in training year 2024.

Plan of Correction ***Directed [redacted] 02/04/2026)***

See attached.
Administrator has met requirements for 2025 year and will continue to meet the required hours for 2026.
1/30/2026
Relias not an acceptable form of Training. PCHA will attend DHS approved education. PCHA received 26 hours of Training for 2025. The additional hours (2) will be made up for being short of the 2 hours in 2024.

Proposed Overall Completion Date: 02/01/2026

Directed Plan of Correction [redacted] - 2/4/26):

Immediately, an annual staff training plan shall be developed for the administrator which includes 24 hours of Department-approved training.

Immediately, administrator training shall be monitored monthly and through the quality management process to ensure each administrator has 24 hours of Department approved training annually.

Directed Completion Date: *02/04/2026*

Implemented [redacted] - 04/14/2026)

65d - Initial Direct Care Training

4. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs

65d - Initial Direct Care Training *(continued)*

iii. Personal hygiene.
iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
vi. Implementation of the initial assessment, annual assessment and support plan.
vii. Nutrition, food handling and sanitation.
viii. Recreation, socialization, community resources, social services and activities in the community.
ix. Gerontology.
x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the home.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. Infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [redacted], began providing unsupervised ADL services on [redacted]. However, the staff person did not complete the Department-approved direct care training course and pass the competency test until [redacted]
Direct care staff person C, hired on [redacted], began providing unsupervised ADL services on [redacted]. However, the staff person did not complete the Department-approved direct care training course and pass the competency test until [redacted]

Plan of Correction ***Directed ([redacted] - 02/04/2026)***

HR will have all staff that are required for direct care staff training be complete during orientation. PCHA/designee will review the checklist to ensure that all requirements are fulfilled prior to working on the unit. Review with the staff during QAPI meeting.
1/30/2026
An audit of the current staff was done on 1/20/2026. The PCHA/ HR Assistant will audit for New Hires and will monitor for all new staff.

Proposed Overall Completion Date: 02/01/2026

Directed Plan of Correction [redacted] - 2/4/26):

To clarify the above plan of correction, beginning within 5 days of the receipt of the acceptable plan of correction, the administrator or designee shall conduct a monthly audit of newly hired direct care staff for six month.

Directed Completion Date: *02/09/2026*

Implemented [redacted] - 04/14/2026)

65e - 12 Hours Annual Training

5. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.

65e 12 Hours Annual Training *(continued)*

2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person D, hired on [redacted], did not receive any training in training year 2024.

Repeat Violation: [redacted] et al.

Plan of Correction ***Accept ([redacted] - 02/04/2026)***

See attached.
The staff member has completed the required 12 hours for training in 2025. PCHA/ Designee will do monthly audits to ensure that staff complete the required hours per year that will be a calendar reminder at the beginning of each month.
1/30/2026
An audit has been conducted on 1/21/2026 to ensure that all staff were up to date. PCHA/designee will perform monthly audits x2 starting on 1/30/26 to ensure all staff are up to date.

Licensee's Proposed Overall Completion Date: *02/01/2026*

Implemented [redacted] - 04/14/2026)

81b - Resident Personal Equipment

6. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident [redacted]'s bed was equipped with a bedside mobility device, which was not securely attached to the bed frame and could be pulled out easily, creating an 8 inch entrapment zone. Present within the device was an opening measuring 18 inches x 20 inches, which was not covered.

Repeat Violation: [redacted] et al.

Plan of Correction ***Directed [redacted] - 02/04/2026)***

See attached.
PC removed the bedside mobility device and maintenance installed the approved Halo to have attached to the bed.
Maintenance will assess the bed and current devices that are being used.
Staff will review during QA meeting on 2/3/2026 will all the departments.
1/30/2026
An audit of the current bed mobility devices was performed on 1/21/2026. Any new bedside mobility devices are required to meet the FDA guidelines. Maintenance will do the measurements at time it's applied. Any new devices will be submitted by the PCHA/deisgne.

Proposed Overall Completion Date: 02/01/2026

Directed Plan of Correction ([redacted] - 2/4/26):

81b - Resident Personal Equipment (continued)

Immediately, the administrator shall review the home's bedside mobility policy to ensure that the frequency of maintenance checks for devices are included in the plan.

Beginning within 10 days of the receipt of the acceptable plan of correction, the administrator shall ensure maintenance of bedside mobility devices are inspected regularly, as defined in the home's written policies and procedures.

Directed Completion Date: *02/14/2026*

Implemented ([redacted] - 04/14/2026)

100b - Removal Snow/Obstructions

7. 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 [redacted] at 10:00 AM, there was an approximate 2 inch accumulation of snow covering the walkway and patio outside of the Garden View dining room. On [redacted] at 11:09 AM, there was an approximate 2 inch accumulation of snow covering the ground and stairs outside of the emergency exit #22 located near personal care room number [redacted]. According to the National Oceanic and Atmospheric Administration (NOAA), approximately 7 inches of snow accumulated in the area where the home is located on [redacted]

Plan of Correction ***Accept [redacted] - 02/04/2026)***

Education w/maintenance and review of the requirements for removal of snow/obstructions. PCHA/ Designee will also monitor during inclement weather to ensure safety.
1/30/2026
Snow was removed on 12/16/2025 by the maintenance staff. PCHA/Maintenance staff will monitor walkways/egress during inclement weather for compliance. Staff reviewed on 1/20 & 1/21 and will be discussed during the QAPI meeting on 2/3/26

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

Implemented [redacted] - 04/14/2026)

103e - Left Overs

8. Requirements

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

Description of Violation

On [redacted] at 10:00 AM, cartons of chocolate, chocolate marshmallow and vanilla ice cream were observed in the Garden View Kitchenette freezer. They were opened but not labeled with a date.

Plan of Correction ***Directed [redacted] 02/04/2026)***

See attached.
Reviewed with the staff. A checklist was added to the kitchen to be performed weekly. Will review during QAPI

103e - Left Overs (continued)

meeting with Dietary and other Departments. Staff meeting was held to review plans for the new audit sheet to be implemented.
1/30/2026
The ice cream was discarded on 12/16/2025. The staff meeting was held on 1/20 &1/21 to review the regulations. PCHA/ Dietary Supervisors will monitor compliance with the checklist to ensure that all food is labeled in the refrigerator.

Proposed Overall Completion Date: 02/01/2026

Directed Plan of Correction [redacted] - 2/4/26):

Within 10 days of receipt of the accepted plan of correction, the administrator shall educate all staff persons handling, preparing or storing food items regarding the safe storage of food items including labeling, dating, storing food in closed or sealed containers and not storing food on the floor. Documentation of education shall be kept.

Within 10 days of receipt of the accepted plan of correction, a designated staff person will check all food storage areas daily including refrigerators and freezers to ensure all food items are labeled, dated, stored in closed or sealed containers and that food is not stored on the floor.

Within 10 days of receipt of the accepted plan of correction, the administrator will check all food storage areas, including refrigerators and freezers to ensure all food items are labeled, dated, stored in closed or sealed containers and not stored on the floor, weekly for four weeks then monthly for three months.

Directed Completion Date: *02/14/2026*

Implemented [redacted] - 04/14/2026)

103f - Refrigerator/Freezer Temps

9. Requirements

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

Description of Violation

On [redacted] at 10:08 AM, the temperature in the Country Kitchenette freezer was 2 degrees Fahrenheit and remained at 2 degrees Fahrenheit upon subsequent observation at 11:15 AM.

Plan of Correction ***Directed [redacted] - 02/04/2026)***

See attached.
Reviewed with the staff. A checklist was added to the kitchen to be performed weekly. The checklist will identify several areas including labels, temps, etc. Will review during QAPI meeting with Dietary and other Departments. Staff meeting was held to review plans for the new audit sheet to be implemented.
1/30/2026
The freezer was adjusted to reach the acceptable temperature on 12/16/2025. Dietary supervisor/ PCHA will monitor compliance. The staff meeting was schedule on 1/20/26 and 1/21/26.

103f Refrigerator/Freezer Temps (continued)

Proposed Overall Completion Date: 02/01/2026

Directed Plan of Correction (- 2/4/26):

Within 15 days of receipt of the accepted plan of correction, the administrator shall educate all staff persons involved in food storage and preparation on safe food storage including all refrigerators and freezers have thermometers and food requiring refrigeration is stored at or below 40 degrees Fahrenheit and frozen food is stored at or below 0 degrees Fahrenheit. Documentation of education shall be kept.

Starting 5 days from the receipt of the acceptable plan of correction, the administrator or designee shall check all refrigerators and freezers at least weekly to ensure all refrigerators and freezers have thermometers and food requiring refrigeration is stored at or below 40 degrees Fahrenheit and frozen food is stored at or below 0 degrees Fahrenheit. Documentation of audits shall be maintained.

Directed Completion Date: *02/18/2026*

Implemented 04/14/2026)

121a - Unobstructed Egress

10. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On at 11:09 AM, approximately 2 inches of snow was observed on the ground and stairs outside of the emergency exit #22, blocking egress from the home.

Plan of Correction ***Accept - 02/04/2026)***

Education w/ Maintenance and review of the regulation for unobstructed egress. PCHA/ Designee will also monitor during inclement weather to ensure safety. Discussion will be reviewed at QAPI on 2/3/2026
1/30/2026
Snow was removed on 12/16/2025 by the maintenance staff. PCHA/Maintenance staff will monitor walkways/egress during inclement weather for compliance. Staff reviewed on 1/20 & 1/21 and will be discussed during the QAPI meeting on 2/3/26

Licensee's Proposed Overall Completion Date: *02/01/2026*

Implemented - 04/14/2026)

183e - Storing Medications

11. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On two opened insulin pens, Lantus and Novolog, prescribed for resident , were observed in the home's Skyview medication cart without labels indicating the date the medications were opened. According to the

183e - Storing Medications (continued)

manufacturer's instructions, these medications should be discarded 28 days after opening.

Repeat Violation: [redacted] *et al.*

Plan of Correction ***Directed ([redacted] - 02/04/2026)***

See attached.
The two insulin pens for resident [redacted] *have been properly labeled. A house audit was conducted and insulin pens were identified as appropriately labeled. Staff were educated on proper labeling of insulin pens and expiration dates. PCHA/ designee will conduct audit of all insulin pens for correct labeling weekly x 4 weeks, then monthly x2 months. Results of audit will be reviewed at QAPI*
1/30/26
The insulin pen was discarded on 12/15/25. The clinical coordinator performed an audit on 1/11/26. Weekly audits began on 1/18/26. PCHA/clinical coordinator will review at QAPI on 2/3/2026

Proposed Overall Completion Date: 02/01/2026

Directed Plan of Correction [redacted] ***- 2/4/26):***

In addition to, and to clarify the above plan of correction, within 15 days of the receipt of the acceptable plan of correction, all staff who administer medication shall receive training by a licensed nurse or qualified train-the-trainer on the requirements of regulation 183e.

Beginning 10 days from the receipt of the acceptable plan of correction, the administrator or designee shall audit medications weekly for two months then bi-weekly for two months, and monthly for two months.

Directed Completion Date: *02/18/2026*

Implemented [redacted] ***- 04/14/2026)***

185a - Implement Storage Procedures

12. 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

On [redacted] *resident* [redacted] *glucometer was not calibrated to correct time. It displayed 12:32 PM at 11:52 AM.*

Resident [redacted] *is prescribed* [redacted] *twice a day in the morning and at bedtime. On the morning of* [redacted]*, Staff person E administered this medication. However, the staff person did not indicate on the home's narcotic record that this medication was administered. The home's medication policies state "A log should be maintained detailing the type, quantity, and individual administering the medication" under the "Controlled Substance and Narcotics portion of the medication polices.*

Repeat Violation: [redacted] *et al.*

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Directed [redacted] - 02/04/2026)***

See attached.
The glucometer for Resident #[redacted] date and time was corrected. A house audit was conducted: all glucometers were displaying correct date and time. Staff were educated on the importance of accurate date and time being displayed prior to obtaining glucose levels. PHCA/ designee will conduct audit of all glucometers for accurate date and time weekly x4 then monthly x2 months. Results of audit will be reviewed at QAPI.
1/30/26
Resident [redacted] glucometer was discarded on 12/16/25 by the clinical coordinator. The audit was completed on 1/11/26. The staff meeting was conducted on 1/20 and 1/21/26. Weekly audit begin on 1/18/26. PCHA/ clinical coordinator will be responsible for reviewing audits and review at the next QAPI on 2/3/2026.

Proposed Overall Completion Date: 02/03/2026

Directed Plan of Correction ([redacted] - 2/4/26):

In addition to, and to clarify the above plan of correction, within 10 days of the receipt of the acceptable plan of correction, all staff who administer medication shall receive training by a licensed nurse or qualified train-the-trainer on the requirements of regulation 185a.

Beginning 15 days from the receipt of the acceptable plan of correction, the administrator or designee shall audit glucometers and perform Medication Records and cart audits weekly for two months then bi-weekly for two months, and monthly for two months.

Directed Completion Date: *02/18/2026*

Implemented [redacted] - 04/14/2026)

13. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident [redacted] is prescribed [redacted] as needed. On [redacted], this medication was not available in the home.

Plan of Correction ***Directed [redacted] - 02/04/2026)***

See attached.
Resident [redacted] has been hospitalized and all orders have been discontinued. A house audit of medication availability has been conducted; orders have been adjusted and medications needed to be ordered have occurred. Staff have been educated on the importance of assuring medications ordered are available to the residents. The PCHA/designee will conduct weekly audit of 10 residents per week x4 weeks to assure all medications ordered are available then monthly x2months. Results of the audit will be reviewed at QAPI.
1/30/26
Staff were educated on the staff meetings held on 1/20/26 & 1/21/26. The audits started on 1/19/26 by the clinical coordinator. PCHA/clinical coordinator will be reviewed at QAPI on 2/3/26

185a Implement Storage Procedures (continued)

Proposed Overall Completion Date: 02/03/2026

Directed Plan of Correction [redacted] - 2/4/26):

In addition to, and to clarify the above plan of correction, within 10 days of the receipt of the acceptable plan of correction, all staff who administer medication shall receive training by a licensed nurse or qualified train the trainer on the requirements of regulation 185a.

Beginning 15 days from the receipt of the acceptable plan of correction, the administrator or designee shall audit medications weekly for two months then bi weekly for two months, and monthly for two months.

Directed Completion Date: *02/18/2026*

Implemented [redacted] - 04/14/2026)

187b - Date/Time of Medication Admin.

14. 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 [redacted] is prescribed [redacted] as needed. The resident's December medication administration record (MAR) does not include the initials of staff person F, who signed out this medication on the Controlled Drug Receipt and administered this medication on [redacted] at 03:16 PM.

Resident [redacted] is prescribed [redacted] twice a day in the morning and at bedtime. According to the controlled medication log, this medication was signed out on [redacted] at 7:40pm and on [redacted] at 9:47 in the morning. However, the resident's December MAR did not indicate that this medication was administered at these dates/times.

Plan of Correction ***Directed ([redacted] - 02/04/2026)***

See attached.
Resident [redacted] had no ill effect for the incident of 12/3. Resident [redacted] has passed away. Staff have been educated on the importance of proper documentation with medication administration. A house audit was conducted for proper documentation of narcotics. The PCHA/designee will audit narcotic records of all residents weekly x4 weeks then monthly x2 months. Results of the audit will be reviewed at QAPI
1/30/26
Staff meeting was held on 1/20/26 and 1/21/26. Audits were started on 1/15/26 by the clinical coordinator. PCHA/ clinical coordinator will review at QAPI on 2/3/26.

Proposed Overall Completion Date: 02/03/2026

Directed Plan of Correction (CM - 2/4/26):

In addition to, and to clarify the above plan of correction, within 10 days of the receipt of the acceptable plan of correction, all staff who administer medication shall receive training by a licensed nurse or qualified train the trainer on the requirements of regulation 187b.

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

Beginning 15 days from the receipt of the acceptable plan of correction, the administrator or qualified medication train-the-trainer shall perform three medication observations per week for two weeks, then bi-weekly for two months, then monthly for two months. . The administrator or designee shall additionally audit medications, medication carts, medication records, and narcotic control logs weekly for two months then bi-weekly for two months, and monthly for two months.

Directed Completion Date: *02/18/2026*

Implemented [redacted] - 04/14/2026)

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] 1 tab by mouth twice a day with a special instruction of 'Hold for heart rate less than 55 and systolic blood pressure less than 100'. On [redacted] and [redacted] at bedtime, the resident was not administered this medication and the reason was documented as the vitals being out of the parameters for administration; however, the resident's heart rate and/or the blood pressure was not documented on the MAR. On 12/14/2025 at bedtime, the resident was administered this medication but the resident's blood pressure was not documented.

Resident [redacted] is prescribed [redacted] twice a day in the morning and at bedtime. However, the resident was not administered this medication on [redacted] in the morning.

Plan of Correction ***Directed [redacted] - 02/04/2026)***

See attached.
Resident [redacted] has been hospitalized and not returned to the facility. Resident #5 has passed away.
Staff have been educated on the importance of following prescribers instructions and on proper documentation.
PCHA/designee will conduct audit of medications administration weekly x4 weeks then monthly x2 months. Results of audit will be reviewed at QAPI.
1/30/26
Staff meeting was scheduled for 1/20/26 &1/21/26. Audits were performed on 1/15/26. PCHA/clinical coordinator will review the audits on 2/3/26 at the QAPI meeting.

Proposed Overall Completion Date: 02/03/2026

Directed Plan of Correction [redacted] - 2/4/26):

In addition to, and to clarify the above plan of correction, within 10 days of the receipt of the acceptable plan of correction, all staff who administer medication shall receive training by a licensed nurse or qualified train-the-trainer on the requirements of regulation 187d.

Beginning 15 days from the receipt of the acceptable plan of correction, the administrator or designee shall audit

187d - Follow Prescriber's Orders (continued)

medication carts and medication records weekly for two months then bi-weekly for two months, and monthly for two months.

Directed Completion Date: *02/18/2026*

Implemented [redacted] - 04/14/2026)

225a - Assessment 15 Days

16. Requirements

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

Description of Violation

An assessment was not completed for resident [redacted] who was admitted to the home on [redacted]

Plan of Correction ***Directed [redacted] - 02/04/2026)***

See attached.
Assessment for Resident [redacted] has been completed. A house audit of new admits has been conducted and assessments are completed. Staff have been educated on the assessment process. PCHA/designee will audit new admissions weekly for assessment completion x4 weeks then monthlyx2 months. Results of the audit will be reviewed at QAPI. 1/30/26
House audit was completed on 1/19/26 by the clinical coordinator. Staff were educated on 1/0/26 & 1/21/26 by the clinical coordinator. Audits began on 1/22/26. PCHA/clinical coordinator will review at the QAPI meeting on 2/3/26.

Proposed Overall Completion Date: 02/03/2026

Directed Plan of Correction [redacted] - 2/4/26):

In addition to, and to clarify the above plan of correction, within 10 days of the receipt of the acceptable plan of correction, all staff who perform resident assessments and develop support plans shall receive training on the requirements of 225a-c by the administrator or designee.

Directed Completion Date: *02/14/2026*

Implemented [redacted] - 04/14/2026)

225c - Additional Assessment

17. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [redacted]'s most recent assessment was completed on [redacted]

225c Additional Assessment *(continued)*

Plan of Correction ***Directed [redacted] - 02/04/2026)***

See attached.
Assessment for Resident [redacted] has been completed. House audit of assessments brought up to date. Staff have been educated on the Assessment requirements. PCHA/designee will audit assessment weekly x4 weeks to observe annual assessments are completed then monthly x2 months and results of audit will be shared at QAPI.
1/30/26
House audit was completed on 1/19/26 by the clinical coordinator. Staff meeting held on 1/20/26 &1/21/26 by the clinical coordinator. Audits began on 1/22/26 by the clinical coordinator. PCHA/designee will review on at QAPI on 2/3/26.

Proposed Overall Completion Date: 02/03/2026

Directed Plan of Correction [redacted] - 2/4/26):

In addition to, and to clarify the above plan of correction, within 10 days of the receipt of the acceptable plan of correction, all staff who perform resident assessments and develop support plans shall receive training on the requirements of 225a c by the administrator or designee.

Within 15 days of the receipt of the acceptable plan of correction, the administrator shall develop a tracking system for annual assessments and support plans. The administrator shall review this tracking system monthly and perform audits on at least 10% of resident assessments due for each month.

Directed Completion Date: *02/18/2026*

Implemented ([redacted] - 04/14/2026)

227c - Support Plan Revision

18. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident [redacted] initial support plan was completed on [redacted]; the resident was assessed for hospice services on [redacted] and accepted these services on [redacted]; however, the resident's support plan has not been revised/updated.

Plan of Correction ***Directed [redacted] - 02/04/2026)***

See attached.
Resident [redacted] has since passed away, Audit has been conducted and there are presently no residents on hospice services. Staff have been educated on the requirements for adjustments needed to support plan when resident's have a change in condition. PCHA/designee will audit support plans for change of condition weekly x4 weeks then monthly x2 months. Results of the audits will be reviewed at QAPI.
1/30/26
Initial audit conducted on 1/17/26 by the clinical coordinator. Staff meeting scheduled on 1/20/26 &1/21/26 by the clinical coordinator. Audits began on 1/22/26 by the clinical coordinator. PCHA/ clinical coordinator will review at the QAPI meeting on 2/3/26. The next meeting is scheduled for 5/5/26

227c - Support Plan Revision (continued)

Proposed Overall Completion Date: 02/03/2026

Directed Plan of Correction[redacted] 2/4/26):

In addition to, and to clarify the above plan of correction, within 10 days of the receipt of the acceptable plan of correction, all staff who perform resident assessments and develop support plans shall receive training on the requirements of 227c by the administrator or designee.

Within 15 days of the date of the receipt of the acceptable plan of correction, the administrator or designee shall perform a monthly audit of residents whose status has changed to ensure an assessment and support plan has been developed timely, for a period of three months.

Directed Completion Date: *02/18/2026*

Implemented[redacted] - 04/14/2026)