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

March 18, 2026

[redacted], ADM
JAMC OPCO LLC
[redacted]

RE: JAMESON SENIOR LIVING
3345 WILMINGTON ROAD
NEW CASTLE, PA, 16105
LICENSE/COC#: 45578

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/17/2025, 12/18/2025 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: *JAMESON SENIOR LIVING* **License #**: *45578* **License Expiration**: *09/01/2026*

Address: *3345 WILMINGTON ROAD, NEW CASTLE, PA 16105*

County: *LAWRENCE* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *JAMC OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/03/1998* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *66* **Waking Staff**: *50*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/18/2025*

Inspection Dates and Department Representative

12/17/2025 - On-Site: [redacted]

12/18/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *71* **Residents Served**: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *33*

Number of Residents Who:

Receive Supplemental Security Income: *33* **Are 60 Years of Age or Older**: *33*

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

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

12/17/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/09/2026*

01/14/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/16/2026*

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

Inspections / Reviews *(continued)*

01/28/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/16/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/06/2026*

03/18/2026 - Document Submission

Submitted By: [redacted] **Date Submitted**: *03/16/2026*

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

82b - Poisonous Material Storage

1. Requirements

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

On 12/17/25, at 10:47 a.m., there was a clear plastic bottle containing approximately ¼ inches of liquid located in the 1st floor Environmental Services Room. However, there were no identifying labels on the clear plastic bottle.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The immediate action was the unlabeled bottle was removed by the Maintenance Director on 12-17-25.*
- *Storage procedures will be reinforced with staff and staff will be re-educated on proper labeling and storage of all hazardous and poisonous materials in accordance with DHS regulations. Education was completed on 1-6-26 by the administrator.*
- *The facility will ensure all poisonous materials are stored in original containers or clearly labeled secondary containers. Unlabeled containers will not be permitted. The Administrator or designee will conduct periodic checks of chemical storage areas to ensure ongoing compliance and will take immediate corrective action if needed. The checks began on 1-6-26 and will be conducted monthly.*

The immediate action was the unlabeled bottle containing a clear liquid was immediately removed and properly discarded. No residents had access to the item.
The facility will ensure all poisonous materials are stored in original containers or clearly labeled secondary containers. Unlabeled containers will not be permitted. Storage procedures will be reinforced with staff and staff will be re-educated on proper labeling and storage of all hazardous and poisonous materials in accordance with DHS regulations. Education will be on 1-6-26 and ongoing.
The Administrator or designee will conduct periodic checks of chemical storage areas to ensure ongoing compliance and will take immediate corrective action if needed.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented ([redacted] - 03/18/2026)

85a - Sanitary Conditions

2. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

Resident #1 was prescribed Lispro sliding skill inject as directed before meals 70 - 140 = 0 units, 141 - 180 =3 units, 181 - 220 = 6 units, 221 - 260 = 9 units, 261 - 300 = 12 units, 301 - 340 = 15 units, greater than 341 call Dr. However, on 12/13/25, at 12:51 p.m., a blood glucose measurement of 150 was indicated on resident #1's December 2025, Medication Administration Record. This blood glucose reading was not measured on resident #1's glucometer. The blood glucose reading of 150 was measured on a glucometer located in the home's medication cart that was identified as the home's house glucometer. The glucometer labeled as a house glucometer had been used to measure multiple blood glucose reading from unknown persons.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The immediate action was the removal of the glucometer in question by the administrator on 12-18-25.*

85a - Sanitary Conditions (continued)

- *All medication administration staff have been re-educated on the requirement that residents must use their own personal glucometers for blood sugar monitoring. Education included infection control standards, resident specific equipment use and proper documentation. Education took place on 12-22-25 by the administrator.*
- *The administrator or designee will continue to monitor for compliance by conducting monthly med cart audits. The audits began on 1-9-26 by the LPN and will be ongoing.*

The immediate action was the removal of the glucometer in question. It is no longer in the facility. It was used for this resident at this time because the resident's own glucometer did not have the necessary test strips available. The resident supplies [redacted] own and was unable to obtain them. Instead of letting [redacted] go a day with a reading the med tech on duty used the "house glucometer". [redacted] was trying to do the right thing.
All medication administration staff have been re-educated on the requirement that residents must use their own personal glucometers for blood sugar monitoring. Education included infection control standards, resident specific equipment use and proper documentation.
The administrator or designee will continue to monitor for compliance going forward.

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

Implemented ([redacted] - 03/18/2026)

100a - Exterior - Free of Hazards

3. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 12/17/25, at 10:36 a.m., there was a missing slab of cement immediately outside of the "Kitchen Fire Exit". The missing slab of cement created a drop of approximately 4-6 inches presenting a tripping hazard in the evacuation route leading away from the exit.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The area was immediately restricted to prevent injury by the maintenance director on 12-17-25.*
- *Corporate office was informed and plans to replace the missing slab are being made. Due to the winter weather, I do not have a date set yet. I am told within the next 30 days, weather permitting and scheduling contractors. The concrete slab will be replaced to ensure a safe, level exit surface. The maintenance director is overseeing this project.*
- *The Administrator and the Environmental Director will conduct routine environmental safety inspections to ensure all exits and walkways remain free from hazards. The inspections will occur monthly.*

The missing concrete slab at the door was identified as a safety hazard. The area was immediately restricted to prevent injury. There is another exit within 50 feet of this door that will be used if needed until repairs are made. Our corporate office was informed and plans to replace the missing slab are being made. Due to the winter weather, I do not have a date set yet. I am told within the next 30 days, weather permitting and scheduling contractors. The concrete slab will be replaced to ensure a safe, level exit surface. The Administrator and the Environmental Director

100a - Exterior - Free of Hazards (continued)

will conduct routine environmental safety inspections to ensure all exits and walkways remain free from hazards. The door in question is actually in the skilled nursing side of the building, which is under DOH. But we share a kitchen, so it affects us all. It is not an emergency exit for the personal care home residents.

Licensee's Proposed Overall Completion Date: *02/28/2026*

Implemented ([redacted] - 03/18/2026)

103e - Left Overs

4. 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 12/17/25, at approximately 10:35 a.m., there was an undated stainless-steel tray of stuffing on the left middle shelf of the walk-in freezer located in the home's main kitchen.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The undated stainless-steel tray of stuffing was immediately discarded by the dietary manager on 12-17-25.*
- *The kitchen refrigerator was inspected to ensure all remaining food items were properly labeled and dated. The Dietary manager/Administrator re-educated dietary and direct care staff on proper food storage requirements, including dating and labeling all prepared and leftover foods in accordance with DHS regulations. Education occurred on 12-17-25.*
- *Going forward, the dietary manager will conduct routine kitchen inspections to ensure ongoing compliance. These inspections will occur weekly.*

The undated stainless-steel tray of stuffing was immediately discarded. The kitchen refrigerator was inspected to ensure all remaining food items were properly labeled and dated. The Administrator/designee re-educated dietary and direct care staff on proper food storage requirements, including dating and labeling all prepared and leftover foods in accordance with DHS regulations. Going forward, the Administrator or dietary manager will conduct routine kitchen inspections to ensure ongoing compliance.

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

Implemented ([redacted] - 03/18/2026)

108 - Firearms & Weapons

5. Requirements

2600.
108. Firearms, weapons and ammunition shall be permitted on the licensed premises of a home only when the following conditions are met:
5. If a firearm, weapon or ammunition is the property of a resident, there shall be a written policy and procedures regarding the safety, access and use of firearms, weapons and ammunition. A resident may not take a firearm, weapon or ammunition out of the locked cabinet into living areas.

108 - Firearms & Weapons *(continued)*

Description of Violation

On 12/18/25, at approximately 2:30 p.m., the home did not have a Firearms and Weapons Policy.

Plan of Correction ***Accept (- 01/28/2026)***

- *The immediate action was to locate and review the weapons policy and it was sent to [redacted] on 12-19-25.*
- *The corrective action was to print the policy and create a file on my desktop to house all the policies in one place so they are easily accessible. This was done on 12-19-25 by the administrator.*
- *The policy in question is now located in a binder as well as in the computer. This is where all policies will be located for easy accessibility. The administrator will be responsible to maintain and review as needed. This began on 12-19-25 and we will review and revise as needed.*

The policy was located on 12-19-2025 and submitted to [redacted]. I will attach the policy here. Going forward all policies will be kept in a binder in the administrator's office and will be updated as needed.

Licensee's Proposed Overall Completion Date: *01/19/2026*

Implemented (- 03/18/2026)

141a 1-10 Medical Evaluation Information

6. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #2's most recent Documented Medical Evaluation completed on [redacted] did not include a special Health or Dietary Needs Assessment. The field was blank.

Plan of Correction ***Accept (- 01/28/2026)***

- *The immediate action was to contact the physician and complete the DME in question. This was completed by the facility LPN on 12-19-25.*
- *All DME's will be reviewed by the facility LPN or designee upon receipt for completion. All DME's were*

141a 1-10 Medical Evaluation Information (continued)

reviewed on 12-30-25 by the Administrator to ensure all current DME's were completed.

- *A review of all DME's will be conducted quarterly with the next review due in the beginning of April 2026. This will be conducted by the administrator or designee.*

The personal care home will ensure that all DMEs are completed in full prior to acceptance or continued residency. For the cited individual, the physician was contacted, and the medical evaluation was completed with the dietary needs section completed. The completed form has been placed in the resident's record.

To prevent reoccurrence, the Administrator or designee will review all medical evaluation forms upon receipt to ensure all required fields are completed. Any incomplete forms will be returned to the physician for completion before being accepted. Staff have been educated on the requirement to verify completeness of medical evaluations. Ongoing audits of resident records will be conducted by the administrator or designee to ensure compliance.

Licensee's Proposed Overall Completion Date: *04/01/2026*

Implemented ([redacted] - 03/18/2026)

144b - Policy on Smoking

7. Requirements

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

On 12/17/25, at 11:56 a.m., there were approximately 2 dozen cigarette butts in the blue/green planter located approximately 15 feet from the home's main entrance. However, the there are no designated smoking areas on grounds.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The immediate action was to locate the policy on smoking which was found in the contract, and I have attached it here. Page 7, I, 1.This was found on 12-19-25 by the administrator. The planter was cleaned and removed by maintenance on 12-19-25.*
- *The administrator will maintain the contract and ensure any incoming residents are aware of the policy as well as current residents and their families.*
- *Administrator/designee will monitor the area for continued issues.*

The home rules as stated in the contract (See attached) on page 7, I. 1. We are a non-smoking facility. Administration and staff will be more vigilant about visitors smoking outside of the building. The planter has been cleaned and removed. Administrator/designee will monitor the area for continued issues.

Licensee's Proposed Overall Completion Date: *01/19/2026*

144b - Policy on Smoking *(continued)*

Implemented (- 03/18/2026)

181d -Storing Medication

8. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #3 self-administers medications and stores medications in room. On 12/18/25, at 3:21 p.m., there were several unlocked, unattended medications to include hydrocodone acetaminophen 5 mg take ½ tab every 6 hours.as needed in an unlocked cabinet above the kitchen sink located in resident #3's private resident room. Resident #3 indicates regularly leaves resident room's door unattended/unlocked when is eating meals and engaging in activities throughout the home.

Plan of Correction ***Accept (- 01/28/2026)***

- *Immediate action was taken by removing the medications from the resident's room by the administrator on 12-18-25.*
- *The resident was counseled on the requirement of securing door when leaving room to ensure safety. is fully aware and understands this responsibility. Staff has been educated on the requirement and will assist the resident by reminders and checking door when is out of room. This occurred on 12-19-25 by the administrator.*
- *Administrator and staff will continue to assist the resident with reminders and spot checks. The resident of aware of this requirement and if it is not followed, will relinquish medications for us to handle. Administrator/designee will continue to monitor for compliance for the foreseeable future.*

Immediate action was taken by removing the medications from the resident's room. After discussion with the resident the medications were returned. Resident has been counseled on the requirement of securing door when leaving room to ensure safety. Staff will remind and assist the resident, as needed, to lock door when exiting. Compliance will be monitored during routine checks and ongoing reminders will be provided as part of staff supervision and resident support. Resident is fully aware and understands this regulation and if wishes to continue needs to comply with this requirement.

Licensee's Proposed Overall Completion Date: *01/19/2026*

Implemented (- 03/18/2026)

181e - Capable to Self Administer

9. Requirements

2600.
181.e. To be considered capable to self-administer medications, a resident shall:

181e - Capable to Self Administer *(continued)*

Description of Violation

Resident #3 self-administers medications to include hydrocodone acetaminophen 5 mg take ½ tab every 6 hours as needed. However, resident #3 indicates [redacted] regularly self-administers 1 hydrocodone tab at night before bedtime.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The immediate action was to check the order, and it was determined that the resident was taking the medication correctly. This was done on 12-18-25 by the administrator. The order is attached.*
- *The Administrator or designee will continue to monitor to ensure correct dosage is being used and that the resident is able to continue to administer [redacted] own medication.*
- *A monthly review with the resident will be conducted for 3 months. The first review was completed on 12-19-25. Then on 1-19-26(today) and on 2-19-26. This review will be with the resident and the administrator or designee. Then, in conjunction with [redacted] doctor, an annual assessment will be conducted with additional reviews if medications change or we feel it is necessary.*

I have attached a copy of the order for this medication. It is written as "1-2 tablets by mouth every 6 hours as needed". Resident has been taking the medication properly. I have also included the pharmacy label and our active medication list. Administrator or designee will continue to monitor to ensure correct dosage is being used and that the resident is able to continue to administer [redacted] own medication. A monthly review with the resident will be conducted for 3 months. Then, in conjunction with [redacted] doctor, an annual assessment will be conducted with additional reviews if medications change or we feel it is necessary.

Licensee's Proposed Overall Completion Date: *02/19/2026*

Implemented ([redacted] - 03/18/2026)

183b - Meds and Syringes Locked

10. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

Resident #3 was assessed to self-administer medications. Resident #3 was prescribed hydrocodone acetaminophen 5mg take ½ tab every 6 hours as needed. This medication was located in an unlocked cabinet above the kitchen sink located in #3's private resident room. Resident #3 indicates [redacted] regularly leaves [redacted] resident room's door unattended/unlocked when [redacted] is eating meals and engaging in activities throughout the home.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *Immediate action was taken on 12-18-25 by the administrator by removing the medications from the resident's room.*
- *The resident was counseled on the requirement of securing [redacted] door when leaving [redacted] room to ensure safety. [redacted] is fully aware and understands this responsibility. Staff has been educated on the requirement and will assist the resident by reminders and checking [redacted] door when [redacted] is out of [redacted] room. This occurred on 12-19-25 by the administrator.*
- *Administrator and staff will continue to assist the resident with reminders and spot checks. The resident of aware of this requirement and if it is not followed, [redacted] will relinquish [redacted] medications for us to handle.*

183b - Meds and Syringes Locked (continued)

Administrator/designee will continue to monitor for compliance for the foreseeable future. Spot checks have been completed on several days, including today, 1-22-26, and the resident has maintained locking the door to [redacted] apartment. Today's check was while [redacted] was at lunch.

Immediate action was taken by removing the medications from the resident's room. After discussion with the resident the medications were returned. After speaking with the resident, [redacted] said [redacted] did lock [redacted] door, just not all the time. Resident has been counseled on the requirement of securing [redacted] door when leaving [redacted] room at all times to ensure safety. Staff will remind and assist the resident, as needed, to lock [redacted] door when exiting. Compliance will be monitored during routine checks and ongoing reminders will be provided as part of staff supervision and resident support. Resident is fully aware and understands this regulation and if [redacted] wishes to continue, [redacted] needs to comply with this requirement.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented ([redacted] - 03/18/2026)

183d - Prescription Current

11. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 12/17/25, at 10:51 a.m., there was a tube of Asper Cream and a bottle of Acetaminophen 500 mg located on resident #4's bedside dresser. However, neither medication was prescribed by a physician.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The immediate action was to remove the medications from the resident's room. This was done by the administrator on 12-17.*
- *All staff were educated by the administrator on 12-19-25 on the regulation that residents may only possess medication that has been approved and prescribed by a licensed physician and only if the physician and facility have approved the resident for self-administration. The administrator also counseled the family about proving medications for the resident without the facilities knowledge. All medications must come through the nursing staff, not given directly to the resident.*
- *To prevent this from occurring again the administrator or designee will conduct routine room checks to ensure compliance. This began on 12-19-25 and will continue on an ongoing basis.*

The unprescribed Aspercreme and acetaminophen were immediately removed from the resident's room and properly disposed of per facility policy, in this case it was returned to the family. Staff were re-educated on the requirement that residents may only possess and use medications that are prescribed by a licensed physician. The Administrator or designee will conduct routine room checks to ensure compliance. Compliance will be monitored on an ongoing basis.

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

183d - Prescription Current *(continued)*

Implemented ([redacted] - 03/18/2026)

184a - Resident's Meds Labeled

12. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 was prescribed Lantus 25 units inject 25 units sub-Q 2 times daily. However, the medication's pharmacy label did not include the medication's administration directions.

Resident #3 was prescribed hydrocodone acetaminophen 5 mg take ½ tab every 6 hours as needed. However, the medication label indicates hydrocodone acetaminophen 5 mg take 1 or 2 tabs every 6 hours as needed.

REPEAT VIOLATION: 12/18/2024

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The immediate action was to label the Lantus pen. This was done on The box had the pharmacy label but the pen itself was missing the directions. See picture attached. This was completed by our LPN on 1-9-26. Also attached is the pharmacy order from the physician for the hydrocodone. It indicates "1-2 tablets by mouth every 6 hours as needed". This is correct.*
- *All med administration staff were reeducated on 1-9-26 by the administrator about medication label requirements and documentation procedures. Any medication found without complete labeling will be immediately removed from use and returned to the pharmacy for correction, or, if possible, will be labeled by hand with all necessary information.*
- *The home will ensure that all prescription medications have a pharmacy label that includes the prescribed dosage and clear instructions for administration prior to use. The Administrator/designee will audit all resident medications upon receipt and during monthly medication reviews to verify compliance. Compliance will be monitored through routine audits to prevent recurrence. Monthly audits will begin on 2-2-26.*

The immediate action was to label the Lantus pen. The box had the pharmacy label but the pen itself was missing the directions. See picture attached.
Also attached is the pharmacy order from the physician for the hydrocodone. It indicates "1-2 tablets by mouth every 6 hours as needed". This is correct.
The home will ensure that all prescription medications have a pharmacy label that includes the prescribed dosage and clear instructions for administration prior to use. Any medication found without complete labeling will be immediately removed from use and returned to the pharmacy for correction. The Administrator/designee will audit all resident medications upon receipt and during monthly medication reviews to verify compliance. Staff will be re-educated on medication label requirements and documentation procedures. Compliance will be monitored through routine audits to prevent recurrence.

184a - Resident's Meds Labeled *(continued)*

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

Implemented ([redacted] - 03/18/2026)

185a - Implement Storage Procedures

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

On 12/18/25, approximately 2:30 p.m., the home did not have a Medication Policy.

On 12/18/25, at 10:48 a.m., resident #1's glucometer indicated a date and time of 12/18/25, 9:36 a.m.

Resident #4 was prescribed acetaminophen 650 mg every 6 hours as needed. However, on 12/18/25, the medication was not in the home.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The medication policy is attached and was found on 12-19-25 by the administrator.*
- *The immediate action was to reset the glucometer and correct the time/date stamp. This was done on 1-8-26 by the LPN. The acetaminophen has been replaced. The resident's family was informed of the order and the need for it to be replaced. I have attached a picture of the bottle and label.*
- *All medication-trained staff were re-educated on proper medication storage, accountability, and equipment accuracy, including the importance of verifying glucometer settings prior to use. This occurred on 1-9-26 by the administrator.*
- *The administrator or designee will conduct weekly audits of the medication cart and glucometer logs for 30 days, then monthly thereafter, to ensure ongoing compliance. Weekly audits are going well. Monthly will begin on 2-2-26.*

The medication policy was found and is attached.
The glucometer in question has been adjusted. When the battery was changed the time was not reset. It has been reset and the correct time and date is correct.
The acetaminophen has been replaced. The resident's family was informed of the order and the need for it to be replaced. I have attached a picture of the bottle and label.
All medication-trained staff were re-educated on proper medication storage, accountability, and equipment accuracy, including the importance of verifying glucometer settings prior to use.
The administrator or designee will conduct weekly audits of the medication cart and glucometer logs for 30 days, then monthly thereafter, to ensure ongoing compliance.

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

Implemented ([redacted] - 03/18/2026)

185b - Medication Procedures

14. Requirements

2600.
185.b. At a minimum, the procedures must include:

Description of Violation

On 12/18/25 approximately 230 p.m., The home did not have a Controlled Medication Policy.

Resident #3 was assessed to self-administer medications. Resident #3 was prescribed hydrocodone acetaminophen 5mg as needed ½ tab every 6 hours. This medication was located in an unlocked cabinet above the kitchen sink located in resident #3's private resident room. Resident #3 indicates [redacted] regularly leaves [redacted] resident room's door unattended/unlocked when [redacted] is eating meals and engaging in activities throughout the home. The home's procedures for the safe use of the medication do not include a method to document the receipt of the medication, a process to investigate and account for missing medications and medication, limited access to the medication's storage area, and documentation of the administration of the medication.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The immediate action was to locate the policy. This was done by the administrator on 1-7-26. It is attached.*
- *The corrective action was to print the policy and place it in a binder in the administrator's office. This was also done by the administrator on 1-7-26.*
- *The preventative action will be a review of all policies during the annual quality management meeting which is held in July. This review will be conducted by the administrator or designee in July 2026.*
- *The resident is question is of sound mind and is capable of self administration. The resident was counseled on the requirement of securing [redacted] door when leaving [redacted] room to ensure safety. [redacted] is fully aware and understands this responsibility. Staff has been educated on the requirement and will assist the resident by reminders and checking [redacted] door when [redacted] is out of [redacted] room. This occurred on 12-19-25 by the administrator.*
- *Administrator and staff will continue to assist the resident with reminders and spot checks. The resident of aware of this requirement and if it is not followed, [redacted] will relinquish [redacted] medications for us to handle. Administrator/designee will continue to monitor for compliance for the foreseeable future. Spot checks have been completed on several days, including today, 1-22-26, and the resident has maintained locking the door to [redacted] apartment. Today's check was while [redacted] was at lunch.*

I have the controlled medication policy. See attached policy. All policies are located in a binder in the administrator's office. This will be updated as needed.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented ([redacted] - 03/18/2026)

187a - Medication Record

15. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
5. Dosage form.

187a - Medication Record *(continued)*

6. Dose.
7. Route of administration.
8. Frequency of administration.

Description of Violation

Resident #1 was prescribed Melatonin 3mg tab administer one tablet daily. However, the medication's dosage form, dose, route of administration frequency of administration were not indicated on the resident's December 2025, Medication Administration Record.

Resident #1 was prescribed Melatonin administer 1 tablet daily. The resident was not administered the medication from 12/17/25, through 12/26/25. However, the resident's December 2025, Medication Administration Record indicates that the medication was administered for the corresponding dates.

Resident #1 was prescribed Carvedilol 12.5 mg tab, take 1 tablet by mouth two times a day. However, the resident's December 2025, Medication Administration Record indicates Carvedilol 6.25 mg administer 1 tab two times daily.

Resident #4 was prescribed. Lactulose 10gm / 15ml give 30ml by mouth 3 times a day. However, the resident's December 2025, Medication Administration Record indicates Lactulose 10G / 15ml 30ml orally 3 times a day as needed.

REPEAT VIOLATION: 12/18/2024

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The facility immediately corrected the identified deficiencies by reviewing the affected resident's MAR and ensuring all required information was complete and accurate. Physician order changes were verified and properly documented in the resident record. This happened on 12-19-25 by the administrator and med staff.*
- *To prevent recurrence, the Administrator has re-educated staff on accurate and timely documentation of the MAR and all physician order changes. Staff will be reminded that order changes must be documented immediately and reflected in all applicable records. This occurred on 12-19-25.*
- *The Administrator/designee will conduct monthly audits of MARs and resident records to ensure completeness and proper documentation of order changes. Any discrepancies will be corrected promptly, and additional training will be provided as necessary. Audits will begin on 2-2-26 and be ongoing.*

The facility immediately corrected the identified deficiencies by reviewing the affected resident's MAR and ensuring all required information was complete and accurate. Physician order changes were verified and properly documented in the resident record.

Resident #1, melatonin; Resident was refusing the melatonin and did not provide the medication when asked. It has since been discontinued, and the order is attached. With regard to the 2nd part of this citation, same medication, med tech staff was not marking the medication properly to show refusal or unavailable but instead marking it as administered. The staff members involved, as well as all medication administering staff have been reeducated on the importance of documenting properly, even if it is an OTC.

The order for the carvedilol has been corrected in the system, and I have attached the med list to show changes.

187a - Medication Record (continued)

Resident #4, lactulose order has been verified and corrected. It is a PRN. Not to be given 3 times a day routine. The pharmacy label was incorrect, but it has been corrected. I have attached the order.

To prevent recurrence, the Administrator/designee will re-educate staff on accurate and timely documentation of the MAR and all physician order changes. Staff will be reminded that order changes must be documented immediately and reflected in all applicable records.

The Administrator/designee will conduct monthly audits of MARs and resident records to ensure completeness and proper documentation of order changes. Any discrepancies will be corrected promptly, and additional training will be provided as necessary.

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

Implemented ([redacted] - 03/18/2026)

187d - Follow Prescriber's Orders

16. Requirements

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

Description of Violation

Resident #1 was prescribed Polyethylene glycol 17 gm, give one scoop by mouth the morning for constipation mixed with 4 - 6 ounces of juice or water. However, resident #1 was not administered the medication on 12/10/25. The medication was not in the home.

Resident #1 was prescribed Lispro sliding skill inject as directed before meals, 70 - 140 = 0 units, 141 - 180 = 3 units, 181 - 220 = 6 units, 221 - 260 = 9 units, 261 - 300 = 12 units, 301 - 340 = 15 units, greater than 341 call Dr. However, on 12/4/25, at 4:30 p.m., the resident had a blood glucose measurement of 226 and was administered 6 units of Lispro.

Resident #1 was prescribed melatonin 3 mg administer 1 tablet daily. However, the resident was not administered the medication on 12/5/2025. The medication was not in the home.

Resident #1 was prescribed Melatonin 3 mg administer 1 tablet daily at 9:00 p.m. However, on 12/17/25, the medication was administered at 12:01 a.m.

REPEAT VIOLATION: 12/18/2024

Resident #4 was prescribed Lactulose oral solution 10 gm / 15 ml give 30ml by mouth three times a day for bowel management. However, the resident was not administered this medication on multiple dates to include 12/5/25, through 12/15/25.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The incidents in question were all immediately reviewed by the administrator and issues were identified. All involved parties have been addressed and educated with regard to each incident. 12-19-25.*
- *The home has corrected the cited deficiencies by immediately reviewing all current physician orders for the affected resident and ensuring medications are administered exactly as prescribed. The Administrator reviewed the medication administration process with all direct care staff, emphasizing that medications*

187d - Follow Prescriber's Orders (continued)

must be administered in accordance with prescriber directions regarding dosage, time, route, and special instructions. Staff were re-instructed that no deviations from physician orders are permitted without documented authorization. Additional med staff education included the importance of documenting medication administration completely and correctly. This also occurred on 12-19-25.

- *To prevent recurrence, the Administrator or designee will ensure that physician orders are reviewed and accurately transcribed onto the Medication Administration Record (MAR) upon receipt and with any change in orders. The Administrator or designee will conduct ongoing monitoring through routine audits of MARs and medication administration practices to ensure continued compliance. Any identified discrepancies will be addressed immediately through corrective action and additional staff training. MAR audits will take place weekly for 6 weeks and then monthly for 6 months.*

The incidents in question were all immediately reviewed by the administrator and issues were identified. All involved parties have been addressed and educated with regard to each incident.

The home has corrected the cited deficiencies by immediately reviewing all current physician orders for the affected resident and ensuring medications are administered exactly as prescribed. The Administrator reviewed the medication administration process with all direct care staff, emphasizing that medications must be administered in accordance with prescriber directions regarding dosage, time, route, and special instructions. Staff were re-instructed that no deviations from physician orders are permitted without documented authorization. Additional med staff education included the importance of documenting medication administration completely and correctly.

To prevent recurrence, the Administrator or designee will ensure that physician orders are reviewed and accurately transcribed onto the Medication Administration Record (MAR) upon receipt and with any change in orders. The Administrator or designee will conduct ongoing monitoring through routine audits of MARs and medication administration practices to ensure continued compliance. Any identified discrepancies will be addressed immediately through corrective action and additional staff training. MAR audits will take place weekly for 6 weeks and then monthly for 6 months.

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 03/18/2026)

223a - Description of Service

17. Requirements

2600.
223.a. The home shall have a current written description of services and activities that the home provides including the following:

Description of Violation

On 12/18/25, approximately 230 p.m., The home did not have a Description of Services.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

The facility does have a description of services in the contract. I have attached that to this POC. I am not sure why

223a - Description of Service (continued)

it was overlooked but it is included in the contract all residents have signed.
Page 3, section IV

- *The description of services was found in the contract. I have attached the contract. Page 3, section IV on12-19-25.*

Licensee's Proposed Overall Completion Date: *01/21/2026*

Implemented ([redacted] - 03/18/2026)

223b - Service Procedures

18. Requirements

2600.
223.b. The home shall develop written procedures for the delivery and management of services from admission to discharge.

Description of Violation

On 12/18/25, the home did not have written procedures for the delivery and management of services from admission to discharge.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The immediate action was to review contract where all the information was found. This was done by the administrator on 12-18-25.*
- *The home has developed and implemented written procedures addressing the delivery and management of services from admission through discharge. This is all in the contract and is explained prior to signing the contract upon admission. Procedures include admission assessments, development and implementation of support plans, ongoing monitoring of resident needs, documentation of services provided, coordination with outside providers, and discharge planning. All current residents were reviewed to ensure services are delivered in accordance with the written procedures. The Administrator is responsible for oversight and ongoing compliance. Staff have been educated on the procedures, and compliance will be monitored through routine chart audits.*

I have attached our contract for review. The home has developed and implemented written procedures addressing the delivery and management of services from admission through discharge. This is all in the contract and is explained prior to signing the contract upon admission. Procedures include admission assessments, development and implementation of support plans, ongoing monitoring of resident needs, documentation of services provided, coordination with outside providers, and discharge planning. All current residents were reviewed to ensure services are delivered in accordance with the written procedures. The Administrator is responsible for oversight and ongoing compliance. Staff have been educated on the procedures, and compliance will be monitored through routine chart audits.

Licensee's Proposed Overall Completion Date: *01/22/2026*

Implemented ([redacted] - 03/18/2026)

224a - Preadmission Screen Form

19. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1 date of admission [redacted], did not have a preadmission screening completed.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The immediate action was to search the chart, but the form was not found. The administrator then completed a new prescreen and filed it in the resident's chart. The resident is a long-term resident. The prescreen was completed [redacted] by the previous manager. There is no way to fix the situation so the administrator did the best possible thing we could. This was done on 1-7-26.*
- *The Administrator has re-educated the staff on the requirement that a pre-admission screening be completed prior to admission. This was done on 1-7-26 also.*
- *Admission records will be reviewed at the time of admission to ensure compliance. The administrator/designee will review the charts to ensure all required documents are included.*

The missing pre-admission screen is a long term resident, [redacted] has been here since [redacted] The prescreen was completed by the previous administration [redacted]. The administrator reviewed the chart in its entirety, and it was not found. To correct the issue the administrator completed a new form and have placed it in the chart. We will continue to search for the form.

To prevent recurrence, the Administrator/designee will re-educate staff on the requirement that a pre-admission screening be completed prior to admission. Admission records will be reviewed at the time of admission to ensure compliance.

Licensee's Proposed Overall Completion Date: *01/21/2026*

Implemented ([redacted] - 03/18/2026)

227g -Support Plan Signatures

20. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1 participated in the development of [redacted] support plan on [redacted] However, the resident did not sign the support plan. The field was blank.

Plan of Correction ***Accept ([redacted] - 01/28/2026)***

- *The immediate action was to review the RASP with the resident again during which the resident signed the RASP. It was then placed in [redacted] chart. This was done by the LPN on 1-6-26.*
- *Staff was reeducated on the requirement of resident review and signature. This was also done on 1-6-26 by the administrator.*

227g -Support Plan Signatures (continued)

- *Going forward all RASP's will be reviewed for completion by the administrator/designee before they are finalized and placed into resident charts. All charts have audited to ensure compliance and will continue to be audited monthly by the administrator or designee.*

The corrective action was immediate, the RASP was reviewed by the resident and LPN, and the plan was signed by the resident and placed in the resident's chart.
The administrator or designee will verify that all required signatures are obtained before RASP's are finalized. Staff were reeducated on the signature requirements.
RASPs have been audited to ensure compliance and all charts will be audited monthly to ensure continued compliance by the administrator or designee.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented (- 03/18/2026)

254b - Policy and Procedures

21. Requirements

2600.
254.b. Each home shall develop and implement policy and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records.

Description of Violation

On 12/18/25, the home did not have written policies and procedures for managing records.

Plan of Correction ***Accept (- 01/28/2026)***

- *The immediate action was to locate the policy. This was done by the administrator on 1-7-26.*
- *The corrective action was to print the policy and place it in a binder in the administrator's office. This was also done by the administrator on 1-7-26.*
- *The preventative action will be a review of all policies during the annual quality management meeting which is held in July. This review will be conducted by the administrator or designee in July, 2026.*

The policy is attached. All policies are printed and accessible and located in a binder in the Administrators office. All policies will be updated as needed.

Licensee's Proposed Overall Completion Date: *07/21/2026*

Implemented (- 03/18/2026)