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

April 28, 2026

[redacted], EXECUTIVE DIRECTOR
ARHC WHWCHPA01 TRS LLC
1361 EAST BOOT ROAD
EXECUTIVE DIRECTOR
WEST CHESTER, PA, 19380

RE: WELLINGTON COURT AT HERSHEY'S MILL
1361 EAST BOOT ROAD
WEST CHESTER, PA, 19380
LICENSE/COC#: 14136

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/29/2025, 12/30/2025 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: *WELLINGTON COURT AT HERSHEY'S MILL* **License #**: *14136* **License Expiration**: *03/23/2026*

Address: *1361 EAST BOOT ROAD, WEST CHESTER, PA 19380*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *ARHC WHWCHPA01 TRS LLC*

Address: *1361 EAST BOOT ROAD, EXECUTIVE DIRECTOR, WEST CHESTER, PA, 19380*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *01/31/1998* **Issued By**: *East Goshen Township*

Type: *I-2* **Date**: *01/31/1998* **Issued By**: *East Goshen Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *151* **Waking Staff**: *113*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/30/2025*

Inspection Dates and Department Representative

12/29/2025 - On-Site: [redacted]

12/30/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *114* **Residents Served**: *96*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *40* **Residents Served**: *35*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *96*

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

Have Mobility Need: *55* **Have Physical Disability**: *2*

Inspections / Reviews

12/29/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/06/2026*

Inspections / Reviews *(continued)*

02/12/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/27/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/04/2026*

04/28/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/27/2026*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 12/29/2025, at 9:49 AM, a computer screen was unlocked and open displaying resident information. Additionally, a binder containing resident information and care needs were unlocked, unattended, and accessible on a desk in the common area on the 3rd floor.

Repeat violation: 12/11/2024 et al

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• On 12/29/25, upon notification via DHS, the Med Tech laptop and communication book were immediately secured to prevent unauthorized access to resident information.
• Resident confidentiality was protected on 12/29/25 at time of notification through the immediate securing of all electronic devices and written communication tools containing resident information.
• Current medication technicians and licensed practical nurses (LPNs) will receive re-education by Health and Wellness Director or designee on regulation 2600.17. including proper handling of electronic resident information
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• The Health & Wellness Director or designee will conduct random weekly audits to ensure laptops and electronic records are secured when unattended, the results of the audits will be reported to the Executive Director. Audits will be conducted weekly for 1 month and then monthly for 2 months. Audits will begin February 1, 2026, and conclude April 22, 2026.
• The Executive Director will review outcomes of the weekly audits with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented ([redacted] - 04/28/2026)

25b - Contract Signatures

2. Requirements

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

Description of Violation

The resident-home contract, dated [redacted], for resident 1 was not signed by the resident. There was no indication the resident was given the opportunity to sign the contract.

25b - Contract Signatures *(continued)*

Plan of Correction ***Accept (- 02/11/2026)***

• As noted by DHS on 12/29/25, the residency agreement for (resident #1) was missing the resident's signature, while the resident's had signed the agreement electronically.
• Upon learning of the issue, the community immediately obtained the resident's signature on December 29, 2025, to fully execute the residency agreement.
• Resident rights were protected, as the residency agreement was reviewed with the resident and the resident voluntarily signed the document.
• The fully executed residency agreement is maintained in the resident record to document compliance.
• Current Directors involved in admission and residency agreement process will be retrained on regulation 2600.25 by Regional Director of Operations,
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Trainings will be documented on a Record of Training
• Ongoing compliance will be monitored through a monthly supervisory review of residency agreements to ensure all required signatures are present by the Executive Director or Associate Executive Director.
• The Executive Director will review outcome of the review with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented (- 04/14/2026)

29a SOPb1- Hospice Care: Doctor Certification

3. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
1. A physician, who is not an employee or contractor of the home, has certified in writing that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill.

Description of Violation

Resident 2, who was not evacuated during the fire drill conducted on 4/8/25 at 10:13 AM, does not have a written certification from a physician that the resident is actively dying and may be injured or suffer a hastened death as the result of participating in a fire drill.

Plan of Correction ***Accept (- 02/11/2026)***

• Due to the resident's passing on immediate corrective action related to obtaining signatures was not applicable.
• Current care staff will be re-educated on the regulatory requirements of 55 Pa. Code § 2600.25(b)(1) and (2), including the requirements for obtaining a physician written certification that a resident may not participate in a fire drill due to a terminal condition or actively dying
• Executive Director or Designee will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• The Health & Wellness Director or designee will complete a review of current residents on hospice services or at

29a SOPb1- Hospice Care: Doctor Certification (continued)

end of life to determine evacuation capability with the findings reflected on the service plan. The results of the review will be reviewed by the Executive Director. Review to begin February 1, 2026, with an end date of no later than February 28, 2026.

• The Executive Director or designee will review the fire drill documentation for the next three fire drills to ensure : Current residents are evacuated, residents not evacuated are clearly accounted for and supervised. Review to begin on the unannounced February fire drill and continue through March and April.

• The Executive Director will review outcome of the review and fire drill process with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

29a SOPb2 - Hospice Care: Informed Consent

4. Requirements

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

2. The resident, the resident's power of attorney for health care, the resident's legal guardian or the resident's health care representative has provided written informed consent that the person is not to evacuate in a fire drill.

Description of Violation

There is no statement of informed consent from resident 2, the resident's power of attorney for health care, the resident's legal guardian or the resident's health care representative regarding the resident not evacuating during fire drills. The resident was not evacuated during the fire drill conducted on 4/8/25 at 10:13 AM.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Due to the resident's passing on [redacted] immediate corrective action related to obtaining signatures was not applicable.

• Current care staff will be re-educated on the regulatory requirements of 55 Pa. Code § 2600.25(b)(1) and (2), including the requirements for obtaining a physician written certification that a resident may not participate in a fire drill due to a terminal condition or actively dying

• Executive Director or Designee will conduct the training.

• Training will begin on February 1, 2026.

• All required training will be completed no later than February 28, 2026.

• Completion of training will be documented on a Record of Training.

• The Health & Wellness Director or designee will complete an review of current residents on hospice services or at end of life to determine evacuation capability with the findings reflected on the service plan. The results of the review will be reviewed by the Executive Director . Review to begin February 1, 2026 with an end date of no later than February 28, 2026.

• The Executive Director or designee will review the fire drill documentation for the next three fire drills to ensure : Current residents are evacuated , residents not evacuated are clearly accounted for and supervised. Review to begin on the unannounced February fire drill and continue through March and April.

• The Executive Director will review outcome of the review and fire drill process with the Director team at the next

29a SOPb2 - Hospice Care: Informed Consent (continued)

scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

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 12/27/2025, from 7:00 AM to 7:00 AM on 12/28/2025, 96 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid.

On 12/25/2025, from 7:00 AM to 3:00 PM, 96 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid. From 3:00 PM to 11:00 PM, 96 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, and no staff were present who were certified in obstructed airway techniques and CPR. From 11:00 PM to 7:00 AM on 12/26/25 96 residents were present in the home. During this time only 1 staff person was present in the home who was certified in obstructed airway techniques and CPR, and no staff was certified in first aid.

On 12/24/2025, from 7:00 AM to 3:00 PM, 96 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid.
From 3:00 PM to 11:00 PM, 96 residents were present in the home. During this time no staff person was present in the home who was certified in first aid. From 11:00 PM to 7:00 AM on 12/25/25 96 residents were present in the home. During this time only 1 staff person was present in the home who was certified in obstructed airway techniques, CPR and first aid.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Upon identification by DHS, staffing coverage for the dates of 12/24, 12/25, and 12/27 did not reflect the trained staff that were present in the community.
• Current Directors including the Executive Director will be re-educated on staffing requirements under 55 Pa. Code § 2600.63(a), including required staffing ratios and training expectations.
• The Regional Director of Operations will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• First Aid training was completed on December 31, 2025, for 11 clinical staff and five non-clinical staff. On January 2, 2026, First Aid training completed by 1 clinical staff member and four non-clinical staff members.
• Completion of all training will be documented on a Record of Training.

63a First Aid/CPR Training (continued)

• The Executive Director has reviewed the current schedule to verify that at least one staff person is trained in CPR & first aid per 50 residents. Staffing schedules now verify that at least one first aid and CPR certified staff member is present for every 50 residents. Review to begin February1, 2026, and continue indefinitely.
• The Health & Wellness Director or designee will conduct a monthly review of staff schedules to verify that there is a CPR /First Aid trained staff person for every 50 residents. The review will be conducted with the Executive Director if there is a discrepancy in compliance. Review begins February 1 and continue indefinitely.
• A tracking system was implemented to monitor first aid and CPR certification expiration date, this system will be monitored and reviewed by the HR Director and communicated monthly with the Executive Director of ongoing training that is needed for compliance. Tracking to be monitored by Human Resources and Health and Wellness Director or designee. Tracking to be reviewed weekly at staffing meetings beginning February 1, 2026 and continuing indefinitely.
• The Executive Director will review discuss the schedule expectations with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

65g - Annual Training Content

6. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, and resident rights during training year 1/1/2024 to 12/31/2024.

Staff person B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, and resident rights during training year 1/1/2024 to 12/31/2024.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Upon notification by DHS, it was identified that Staff Person A and Staff Person B, did not receive all required annual training during the training year January 1, 2024 through December 31, 2024, specifically related to fire safety training completed by a fire safety expert or by a staff person trained by a fire safety expert, emergency

65g - Annual Training Content (continued)

preparedness procedures and recognition and response to crises and emergency situations, and resident rights.

• Emergency Preparedness was completed by employee A on January 6, 2026, and documented in Relias.
• Fire Safety Training to be completed for employee A and B on February 18, 2026 at 9:30am and 2pm by fire safety expert, [redacted] .
• The current management team will be re-educated on the annual training requirements outlined in 55 Pa. Code § 2600.65(g). Training will be conducted by the Regional Director of Operations.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Training will be documented on a Record of Training
• Ongoing compliance will be monitored through monthly review of training records to ensure all required annual training elements are completed and documented . Ongoing compliance will be monitored by Business Office Manager or designee and with a start date on February1, 2026 and continuing indefinitely.
• Monitoring will be completed monthly by the Human Resources representative or designee.
• The Executive Director will review current training needs with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented ([redacted] - 04/28/2026)

65i - Training Record

7. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff orientation training does not include the source, and length of each course.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Upon notification by DHS, it was determined that the new hire orientation documentation did not consistently include the trainer name(s) and the total length of training.
• A revised First Day Orientation / Initial Training Record has been developed to clearly document the date of orientation, trainer name(s) and title(s), orientation topics covered, and total length of training . Document created by Executive Director.
• Current management team members responsible for conducting new hire orientation will be trained on the proper completion and use of the revised orientation form.

65i - Training Record (continued)

• The Regional Director of Operations will conduct the training for all management team members.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• The revised First Day Orientation / Initial Training Record will be utilized for all new hires beginning January 5, 2026, to ensure required information is consistently documented.
• Ongoing compliance will be monitored through a monthly review of new hire personnel files to ensure orientation records include the trainer(s) and total length of training.
• Monitoring will be completed monthly by the Human Resources representative or designee.
• The Executive Director will review training expectations /orientation records with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

81b - Resident Personal Equipment

8. 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

On 12/30/2025, resident 3 had a halo brand beside mobility device attached to [redacted] bed. The device was attached securely to the bed frame and contained no entrapment areas that would require a cover based on FDA guidelines. The device was covered by a loose pillowcase which not provided by the manufacturer.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• When reported by DHS, the pillowcase that had been placed on the halo bedside enabler was immediately removed to ensure the device was used in accordance with manufacturer specifications.
• Resident safety was protected by confirming that the halo bedside enabler was free of non-approved coverings that could interfere with the safe use and function of the device.
• Current direct care staff will be re-educated on the proper use of assistive devices, including covers specifically designed and approved for use with the halo bedside enabler may be used, and only at the resident's request.
• The Executive Director or designee will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• The Health & Wellness Director or designee will conduct audits to verify that no Halo has an unapproved covering. Any coverings identified will be removed and reported to the Executive Director. Audits will be conducted weekly for 1 month and then monthly for 2 months. Audits will begin February 1, 2026, and conclude April 22, 2026.
• The Executive Director will review the audit with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

82c Locking Poisonous Materials

9. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 12/29/2025 at 10:18 AM, Antibacterial handwipes, with a manufacture's label indicating "if swallowed get medical help or call poison control", was unlocked, unattended, and accessible to residents in an unlocked cabinet above the kitchen sink in the Secure Dementia Care Unit (SDCU). Not all the residents of the home, including resident 4, have been assessed capable of recognizing and using poisons safely.

Repeat violation: 9/18/2025

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• When reported by DHS, disinfectant wipes found in the Memory Care kitchen were immediately removed by Director of Plant Operations and stored in a secured location not accessible to residents.
• Current direct care staff and current Dining staff will be re-educated on hazardous material storage requirements under 55 Pa. Code § 2600.82(c), including the requirement that disinfectants and other poisonous materials be kept locked and not accessible to residents.
• The Executive Director or designee will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• Ongoing compliance will be monitored weekly by Memory Care Director during supervisory rounds to ensure hazardous materials remain secured.
• Monitoring will be completed monthly by the Health and Wellness Director or designee.
• The Executive Director will discuss the results of manager rounds 7securing hazardous material in the MC neighborhood with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented ([redacted] - 04/28/2026)

85e Trash Outside Home

10. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 12/30/2025 at 1:36 PM there was an old water heater, a stack of 10 pallets, and a large piece of plastic in the parking lot next to the 'out of order' transportation bus.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Upon notification by DHS of the pallets, water heater, and bagged building materials being temporarily staged outdoors while awaiting relocation of an incorrectly positioned dumpster the building materials for an active maintenance project were removed and properly disposed of in the dumpster that had been relocated to it's proper location . Items were removed by Director of Plant Services and maintenance department on January 1, 2026.

85e - Trash Outside Home (continued)

• During the interim period, pallets, a water heater, and bagged building materials associated with an active maintenance project were temporarily staged outdoors while awaiting relocation of the dumpster.
• Supervisory and maintenance staff will be re-educated on physical plant and grounds requirements under 55 Pa. Code § 2600.85(e), including proper storage, placement, and timely removal of maintenance and construction materials.
• The Regional Director of Operations, will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• Ongoing compliance will be monitored through weekly routine supervisory walkthroughs of the grounds for one month and parking areas to ensure materials are properly stored and promptly removed .
• Monitoring will be completed monthly by the Executive Director or designee.
• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

107b - Emergency Procedures

11. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:
1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include contact information for each resident's designated person..

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Upon identification by DHS, the resident emergency contact list was immediately relocated to the Emergency Preparedness Binder maintained at the concierge desk to ensure information is readily accessible during emergencies.
• Resident safety was protected by confirming that the emergency contact list is now stored in a centralized, clearly labeled location designated for emergency preparedness.
• Current management staff and concierge staff will be re-educated on emergency preparedness documentation requirements, including the proper location and maintenance of resident emergency contact information.
• The Regional Director of Operations will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.

107b Emergency Procedures (continued)

• Ongoing compliance will be monitored monthly through supervisory review of the Emergency Preparedness Binder to ensure resident emergency contact information remains current and properly maintained by the Executive Director or designee.
• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

107d - Procedure Emergency Management Agency Submission

12. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures were submitted on 3/5/2025. Prior submission of the homes written emergency procedures occurred on 2/14/2024.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Upon notification by DHS, it was identified that the home's written emergency procedures were not submitted annually to the local emergency management agency within the required timeframe. The most recent submission occurred on March 5, 2025, with the prior submission dated February 14, 2024.
• Resident health and safety were not compromised, as written emergency procedures were in place, reviewed, and actively utilized by the community to guide emergency preparedness and response.
• The home reviewed its written emergency procedures to ensure accuracy and completeness and submitted the updated procedures to the local emergency management agency on March 5, 2025.
• The Executive Director or designee will be re educated on the requirements of 55 Pa. Code § 2600.107(d), including the annual review and submission requirements for written emergency procedures. Training to be conducted my Regional Director of Operations
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Training will be documented on a Record of Training.
• Ongoing compliance will be monitored through an annual supervisory review of emergency preparedness documentation to ensure timely review and submission to the local emergency management agency.
• Monitoring will be completed annually by the Executive Director or designee.
• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

121a - Unobstructed Egress

13. Requirements

121a - Unobstructed Egress *(continued)*

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 12/29/2025 a picture of a stop sign with the words "Stop Not An Exit" were posted on the doors exiting the SDCU and A white cloth with a red stop sign and the words "STOP" was hung across the door leading to exit stairwell 2. This universal image of a stop sign presents an obstruction to the exit in an emergency as it may deter a person from using the exit upon seeing the image.

On 12/30/2025 on the 3rd floor of the home the door to the exit stairwell required a code to be entered for the door to be opened. A code was located on the door frame but was incorrect.

In the SDCU there is an exit next to the dining room labeled "Emergency exit only". The gate to exit the patio area has a manual locking mechanism. There are no instructions near the gate that indicate it's use. To open the gate and exit, one must lift a lever at the top of the gate on the opposite side. The gate itself stands over 6 feet in height, and the lever protrudes an at least additional 5 inches. This would impede the exit of anyone unable to find or reach the lever.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Upon notification by DHS, the stop sign banner located in the Memory Care neighborhood was immediately removed to ensure that all egress routes remain clear and accessible.
• Resident safety was protected by confirming that all stairways, hallways, doorways, passageways, are clearly accessible, and free from obstructions at all times. Review and confirmation completed by Director of Plant Services on December 31, 2025.
• Current direct care staff and maintenance staff will be re-educated on physical plant and life safety requirements under 55 Pa. Code § 2600.121(a), including the requirement that egress routes remain unobstructed and accessible, regardless of the use of visual cueing or safety devices.
• The Executive Director or designee will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• On December 30, 2025, a framed sign was placed within six inches of the third-floor stairwell tower keypad displaying the correct egress code. Signage was created by executive Director and posted by Director of Plant Services
• The existing latching system was removed and will be re-evaluated by the East Goshen Township by Director of Code Enforcement, Fire Marshall, and Zoning Officer.
• Ongoing compliance will be monitored weekly through routine supervisory walkthroughs of the Memory Care neighborhood to ensure all egress routes remain clear. Monitorng will continue indefinitely.
• Monitoring will be completed monthly by the Executive Director or designee.
• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

132b - Safety Inspection/Fire Drill

14. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection observed by a fire safety expert was conducted on 10/23/2025. The previous fire safety inspection observed by a fire safety expert was conducted on 1/24/2024.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Upon notification by DHS, it was identified that the required fire safety information letter was not obtained within the required annual timeframe, resulting in a gap of more than one year between the prior letter and the current letter.
• Resident safety was protected, as fire safety procedures and emergency response practices were in place during the period identified.
• The community does have a current fire safety information letter on file.
• The community leadership team will be re-trained to ensure the fire safety information letter is obtained and distributed annually within the required timeframe. Training to be conducted by Regional Director of Operations.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of Training will be documented on Record of Training.
• Responsibility for tracking and obtaining the annual fire safety information letter has been assigned to the Director of Plant Operations and Executive Director to ensure compliance with the required schedule.
• Ongoing compliance will be monitored through supervisory tracking of the annual fire safety information letter due date.
• Monitoring will be completed annually by the Executive Director or designee.
• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

132h - Designated Meeting Place

15. 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 drill on 12/19/2025 at 6:07 AM, all residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. Residents interviewed on the second floor reported they stood in front of their doors in the hallways to be counted. Staff interviewed reported that residents who are located in the areas without the simulated fire can remain in the halls in front of their doorways.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Upon notification by DHS, evacuation procedures were reviewed to ensure that residents not located within the impacted smoke zone remain within their designated fire-safe area during a fire emergency.
• Resident safety was protected by confirming that each fire-safe hallway provides a straight line of sight and allows residents to relocate within the protected area without opening fire doors or compromising the integrity of the

132h - Designated Meeting Place (continued)

fire-safe zone.

• To further clarify evacuation expectations, the community will designate one room within each fire-safe hallway as a clearly identified relocation area for residents not affected by the smoke zone.

• This designation will allow residents to remain within their fire-safe area without opening fire doors or compromising fire separation.

• Current direct care staff and supervisory staff will be re-educated on fire response and evacuation procedures under 55 Pa. Code § 2600.132(h), including appropriate relocation within fire-safe zones.

• The Executive Director or designee will conduct the training.

• Training will begin on February 1, 2026.

• All required training will be completed no later than February 18, 2026.

• Completion of training will be documented on a Record of Training.

• Ongoing compliance will be monitored through supervisory observation during drills and routine walkthroughs to ensure evacuation procedures are followed as designed.

• Monitoring will be completed monthly by the Executive Director or designee.

• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

181c - Self-administration Assessment

16. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident 3 self-administers medications to include clobetasol 0.05% ointment; however, resident 3 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Upon notification by DHS, the resident's self-administration of medication was immediately reviewed, and self-administration was discontinued until proper assessment, approval, and documentation were completed in accordance with regulatory requirements.

• Resident safety was protected by ensuring that medications were administered by trained staff until the resident was formally assessed and authorized to self-administer medications.

• Current Medication Technicians and Licensed Practical Nurses (LPNs), will be re-educated on medication administration requirements under 55 Pa. Code § 2600.181(c) and the companies self-administer policy including the requirement that residents may not self-administer medications until an order to self-medicate is obtained by a Physician, Physician assistant, or Nurse practitioner

• The Health and Wellness Director or designee will conduct the training.

• Training will begin on February 1, 2026.

181c - Self-administration Assessment (continued)

• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• The Health & Wellness Director or Designee will conduct weekly audits of resident records to verify that self-medication assessments are completed & Physician orders to self-medicate as applicable are completed. Audits will be conducted weekly for 1 month and then monthly for 2 months. Audits will begin February 1, 2026, and conclude April 22, 2026.
• The results of the audit will be reviewed by the ED or designee.
• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

181f - Record of Medication

17. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 12/30/2023, resident 5's record did not include a current list of medications. The list in the resident's record included Clopidogrel 75mg and fludrocortisone .1 mg which the resident reported to no longer be taking and did not include PreserVision AREDS 2 and vitamin b complex.

On 12/30/2023, resident 6's record did not include a current list of medications. The list in the resident's record included Anastrozole 1 mg tablet and Calcitonin-Salmon Nasal Spray which the resident reported to no longer be taking.

Plan of Correction ***Accept ([redacted] - 02/11/2026)***

• Upon notification by DHS, the medication administration records (MARs) for residents #5 & 6 were immediately reviewed and reconciled with the current physician orders. Corrections were made to ensure the medication administration record accurately reflects all current medications as ordered. Completed by the Health and Wellness Director .
• Resident safety was protected by confirming that all medications being self-administered were accurately documented and that current medication information was available for staff oversight.
• Current Medication Technicians and Licensed Practical Nurses (LPNs) will be re-educated on documentation requirements under 55 Pa. Code § 2600.181(f)& the company self-medication policy including the requirement that self-administration MARs remain current and accurately reflect all prescribed medications.
• The Health and Wellness Director, or designee will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• The Health & Wellness Director or Designee will conduct audits to ensure the resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering [redacted] medication. Audits will be conducted weekly for 1 month and then monthly for 2 months. Audits will begin

181f - Record of Medication (continued)

February 1, 2026, and conclude April 22, 2026.

• The results of the audit will be reviewed by the Executive Director or designee.

• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

182b - Prescription Medication

18. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 12/7/2025-12/10/2025 at 8:00 AM staff person B administered medications to residents to include the following: atorvastatin calcium 40 mg tablet, bumetanide 1 mg tablet, and escitalopram 20 mg tablet to resident 7. Staff person B is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

On 12/14/2025 and 12/17/2025 at 5:00 PM staff person C administered medications to residents to include the following; acetaminophen 500 mg caplet, Econazole nitrate 1% cream 85 gm and probiotic 250mg capsule to resident 8. Staff person C is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drops prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction ***Accept ([redacted] - 02/12/2026)***

• Upon notification by DHS, the staff involved were removed from medication administration duties and medication administration was assigned to properly trained and documented staff to administer medication until training was completed.

• Resident safety was protected by ensuring that only qualified and compliant staff administered medications while the identified individuals were removed from medication administration duties.

• Recertification training for the affected Medication Technicians was initiated immediately in accordance with regulatory requirements. Trainings conducted on 12/30/25 – 12/31/25 by a certified Train the Trainer for the DHS Medication Administration Course.

• Medication Technicians did not return to medication carts or resume medication administration duties until all

182b Prescription Medication (continued)

required recertification, competency validation, and authorization requirements were met and reviewed by the Executive Director for compliance.

• The Executive Director implemented a medication administration tracking log for current and newly hired medication technicians The HR Director, Health & Wellness Director and the Executive Director will monitor the training log monthly for compliance and ongoing required competency reviews. Tracking log was implemented on January 7, 2026.

• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

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

Implemented (- 04/14/2026)

183b - Meds and Syringes Locked

19. 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 5 self administers medications and stores medications in room. Resident 5's resides in the room and has not been assessed to self administer medications. On 12/30/2025 resident 5 reported does not lock up medication. Resident 5 pre portions medication into a weekly pill container that is kept in an unlocked drawer by lounge chair. Resident 5 also keeps medication bottles in an unlocked kitchen cabinet.

On 12/30/2025 at 9:28 AM, the medication cart was unlocked, unattended, and accessible in SDCU.

At 1:46 PM clobetasol ointment, over the counter nasal spray and eye drops were unlocked, unattended, and accessible in room 226.

Plan of Correction ***Accept (- 02/12/2026)***

• Upon identification, the medication cart was immediately secured, and medication security expectations were reinforced with staff. In addition, Resident #5 medication storage was reviewed and secured in the resident's apartment in the designated locking drawer as was resident in apartment

• Resident safety was protected by securing all medications and ensuring appropriate storage methods are in place to prevent access by individuals other than the intended resident.

• The residents and spouse were educated on medication security requirements by Health and Wellness Director on December 31, 2025. The resident was instructed to utilize the locking medication drawer provided within the apartment to store medications securely when not in use. Education was provided regarding the importance of maintaining medications in a locked location to prevent unintended access .

• Current Medication Technicians, Licensed Practical Nurses, and applicable clinical leadership will be re educated on medication security requirements, including expectations for resident managed medications in shared living environments, in accordance with 55 Pa. Code § 2600.183(b)& the company's self medication policy and securing the medication cart when not in use .

• The Health and Wellness Director will conduct the training.

• Training will begin on February 1, 2026.

183b - Meds and Syringes Locked (continued)

• All required training will be completed no later than February 18, 2026.
• The Health & Wellness Director or designee will conduct audits of medication storage in resident apartments and random checks to verify that the medications are secured when not in use. Audits will be conducted weekly for 1 month and then monthly for 2 months. Audits will begin February 1, 2026, and conclude April 22, 2026.
• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented ([redacted] - 04/28/2026)

183d - Prescription Current

20. 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 12/30/2025, benzonatate 200 mg capsules prescribed for individual resident 7, was in the home's medication cart; however, the medication was discontinued on 7/20/2025.

Plan of Correction ***Accept ([redacted] - 02/12/2026)***

• Upon notification by DHS, a discontinued medication dated July 20, 2025, for the resident in apartment [redacted] was immediately removed from the medication cart by the Health and Wellness Director.
• Resident safety was protected by ensuring that only current prescription, over-the-counter (OTC), sample, and complementary and alternative medications (CAM) for residents living in the community are maintained on medication carts.
• Current Medication Technicians and Licensed Practical Nurses (LPNs) will be re-educated on medication storage requirements under 55 Pa. Code § 2600.183(d) and the company medication disposition policy including the requirement that discontinued or outdated medications be promptly removed from medication carts.
• The Health and Wellness Director or designee will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• The Health & Wellness Director or designee will conduct an audit of new physician orders to verify that discontinued medications are removed from the med cart upon receiving and noting the order. Audits will be conducted weekly for 1 month and then monthly for 2 months. Audits will begin February 1, 2026, and conclude April 22, 2026.
• The results of the audit will be reviewed by the Executive Director or designee.
• The Executive Director will review audit outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

183e Storing Medications

21. 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 12/30/2025 resident 9's alprazolam .25 mg tablets were in a blister card. The card was punctured at spot 5 and taped over. The pill remained in the packaging.

On 12/30/2025 resident 9's Humalog Kwikpen was dated as opened on 11/30/2025. According to the manufacturer's instructions this medication must be discarded after 28 days.

Plan of Correction ***Accept ([redacted] - 02/12/2026)***

• All affected blister packs were immediately removed from use and replaced to ensure medications were maintained in original, intact packaging without alteration. The Kwikpen was removed and a new Kwik pen was available for use as ordered.
• Resident safety was protected by confirming that only medications maintained in proper condition and packaging were available for administration.
• Current Medication Technicians and Licensed Practical Nurses (LPNs) will be re-educated on medication storage and handling requirements under 55 Pa. Code § 2600.183(e), including that medications may not be altered, taped back into blister cards, or stored in a manner that compromises packaging integrity and training on referring to open dates per manufacturer specifications .
• The Health and Wellness Director, or designee will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• The Health & Wellness Director or designee will audit current Insulin pens and multi-dose medications to ensure proper dating, storage and expiration compliance. Audits will be conducted weekly for one month beginning February 1, 2026, followed by monthly audits for an additional two months. Audits will begin February 1, 2026, and conclude April 22, 2026.
• The results of the audit will be reviewed by the Executive Director or designee.
• The Executive Director will review audit outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented ([redacted] - 04/28/2026)

184b Labeling OTC/CAM

22. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 12/30/2025, a package of prednisolone ophthalmic suspension belonging to resident 10 was in the the home's medication cart and was not labeled with the resident's name.

184b Labeling OTC/CAM *(continued)*

Plan of Correction ***Accept (- 02/12/2026)***

• Upon notification by DHS, it was identified that a medication located on a medication cart was not labeled in accordance with regulatory requirements.
• Upon identification, the unlabeled medication was immediately removed from the medication cart and was not available for administration . Medication was discontinued and medication was not re ordered.
• Resident safety was protected by ensuring that only medications with complete and accurate labeling are stored on medication carts.
• Current Medication Technicians and Licensed Practical Nurses will be re educated on medication labeling requirements in accordance with 55 Pa. Code § 2600.184(b)& the company medication labeling standard.
• The Health and Wellness Director, or designee will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• The Health & Wellness Director or designee will complete a full audit of medications including OTC & CAM products stored in medication carts, resident apartments to verify that medications are labeled with the resident's name . Audits will be conducted for one month beginning February 1, 2026, followed by monthly audits for an additional two months. Audits will begin February 1, 2026, and conclude April 22, 2026.
• The results of the audit will be reviewed by the Executive Director or designee.
• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented (- 04/14/2026)

185a - Implement Storage Procedures

23. 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 11 is prescribed senna 8.6 mg and trazadone 50 mg tablets as needed. On 12/30/2025 these medications were not available in the home.

Plan of Correction ***Accept (- 02/12/2026)***

• Upon notification by DHS, it was identified that medication storage and management procedures were not consistently implemented. This included instances in which ordered PRN medications were not available in the home, glucometers were not calibrated to the correct date and time, and discrepancies were identified between glucometer readings and documentation recorded on the Medication Administration Record (MAR).
• Upon identification, the medication management process related to glucometer calibration, PRN medication availability, and documentation of glucometer readings was immediately reviewed.
• Resident safety was protected by verifying that glucometers in use were calibrated in accordance with manufacturer instructions, required PRN medications were obtained and available as ordered, and blood glucose readings were obtained and documented accurately and timely.

185a Implement Storage Procedures (continued)

• Current Medication Technicians and Licensed Practical Nurses (LPNs) will be re educated on medication management requirements in accordance with 55 Pa. Code § 2600.185(a), including proper calibration and use of glucometers, ensuring ordered PRN medications are available and accessible in the home, and accurate documentation of glucometer readings on the MAR.
• The Health and Wellness Director or designee will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• Ongoing compliance will be monitored through audits of medication availability, glucometer calibration, and MAR documentation. Audits will be conducted weekly for one month beginning February 1, 2026, followed by monthly audits for an additional two months. Audits will begin February 1, 2026, and conclude April 22, 2026.
• Monitoring will be completed by the Health and Wellness Director or designee.
• The results of the audits will be reviewed by the Executive Director or designee.
• The Executive Director will review audit outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented ([redacted] - 04/28/2026)

24. 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 12/30/2025 at 11:19 AM, resident 8's glucometer was not calibrated to the correct date and time and showed 12/3 at 1:39 AM.

On 12/30/2025 at 11:19 AM, resident 12's glucometer was not calibrated to the correct date and time and showed 6/29 at 20:07.

On 12/30/2025 resident 12's glucometer readings showed the following discrepancies on the medication administration record (MAR):

- *On 12/24 at 4:15 PM a reading of 116 was documented in MAR, this reading was not found in the glucometer.*
- *On 12/19 at 4:15 PM a reading of 155 was documented in MAR, this reading was not found in the glucometer.*
- *On 12/12, at 4:15 PM a reading of 136 was documented in MAR, a reading of 126 was in the glucometer.*

Resident 13 is prescribed Novolog Flex Pen subcutaneous solution pen injector, Insulin Aspart. Sliding scale: 0 250, 0 units; 251 300, 1 unit; 301 350, 2 units; 351 400, 3 units. Three times per day every day at 8:00 AM, 12:00 PM, and 5:00 PM. Resident 13's glucometer readings showed the following discrepancies on the MAR:

- *On 12/29 at 12:00 PM a reading of 225 was documented in MAR, this reading was not found in the glucometer.*
- *On 12/26 at 8:00 AM a reading of 261 was documented in MAR, the reading in the glucometer was 264.*
- *On 12/24 at 12:00 PM a reading of 201 was documented in MAR, this reading was not found in the glucometer.*

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept (- 02/12/2026)***

• Upon notification by DHS, it was identified that medication storage and management procedures were not consistently implemented. This included instances in which ordered PRN medications were not available in the home, glucometers were not calibrated to the correct date and time, and discrepancies were identified between glucometer readings and documentation recorded on the Medication Administration Record (MAR).
• Upon identification, the medication management process related to glucometer calibration, PRN medication availability, and documentation of glucometer readings was immediately reviewed.
• Resident safety was protected by verifying that glucometers in use were calibrated in accordance with manufacturer instructions, required PRN medications were obtained and available as ordered, and blood glucose readings were obtained and documented accurately and timely.
• Current Medication Technicians and Licensed Practical Nurses (LPNs) will be re-educated on medication management requirements in accordance with 55 Pa. Code § 2600.185(a), including proper calibration and use of glucometers, ensuring ordered PRN medications are available and accessible in the home, and accurate documentation of glucometer readings on the MAR.
• The Health and Wellness Director or designee will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• Ongoing compliance will be monitored through audits of medication availability, glucometer calibration, and MAR documentation. Audits will be conducted weekly for one month beginning February 1, 2026, followed by monthly audits for an additional two months. Audits will begin February 1, 2026, and conclude April 22, 2026.
• Monitoring will be completed by the Health and Wellness Director or designee.
• The results of the audits will be reviewed by the Executive Director or designee.
• The Executive Director will review audit outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented (- 04/28/2026)

187b - Date/Time of Medication Admin.

25. 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

On 12/30/2025 at during the 11:00 PM to 7:00 AM shift, resident 14 was administered ammonium lactate 12 % cream to [redacted] lower legs by a staff person who was not trained to provide medication. At 8 AM staff person D initialed the MAR indicating [redacted] administered the medication but stated [redacted] did not administer this medication when interviewed.

Repeat violation: 6/23/2025

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

Plan of Correction ***Accept ([redacted] - 02/12/2026)***

• Upon notification by DHS, it was determined that a Medication Technician signed off on the Medication Administration Record (MAR) while not physically present on the medication cart at the time of administration.
• Current Medication Technicians and Licensed Practical Nurses (LPNs) will be re-educated on medication administration and documentation requirements under 55 Pa. Code § 2600.187(b), including that MAR documentation must accurately reflect who administered the medication.
• The Health and Wellness Director or designee will conduct the training.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

187d - Follow Prescriber's Orders

26. Requirements

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

Description of Violation

Resident 13 is prescribed Novolog Flex Pen subcutaneous solution pen injector, Insulin Aspart. Sliding scale: 0-250, 0 units; 251-300, 1 unit; 301 – 350, 2 units; 351-400, 3 units. Three times per day every day at 8:00 AM, 12:00 PM, and 5:00 PM.

On 12/29 at 10:23 AM, the resident's blood sugar reading registered as 351 on the glucometer, requiring 3 units of insulin. No insulin was administered.

On 12/23 at 8:00 AM, the resident's blood sugar reading registered as 257 requiring 1 unit of insulin. No insulin was administered.

Repeat violation: 6/23/2025

Plan of Correction ***Accept ([redacted] - 02/12/2026)***

• Upon identification, the resident's medication administration record and prescriber orders were immediately reviewed to ensure clarity of the insulin sliding scale parameters and administration times.

• Medication Technicians and Licensed Practical Nurses will be re-educated on diabetic management and insulin administration requirements, including strict adherence to prescriber orders and timely administration based on documented blood glucose readings, in accordance with 55 Pa. Code § 2600.187(d). Training will be conducted by Health and Wellness Director or designee. Training will begin on February 1, 2026 and conclude no later than February 28, 2026.
• Diabetic management training was conducted on December 30, 2025, and January 14, 2026, for all Medication Technicians by [redacted].

187d - Follow Prescriber's Orders (continued)

• The Health and Wellness Director or designee will conduct an education and oversight related to insulin administration and prescriber order compliance.
• Training will begin on February 1, 2026.
• All required training will be completed no later than February 18, 2026.
• Completion of training will be documented on a Record of Training.
• Ongoing compliance will be monitored through review of medication administration records and glucometer readings to ensure insulin is administered in accordance with prescriber orders.
• Monitoring will be completed monthly by the Health and Wellness Director or designee beginning February 1, 2026 and concluding on February 28, 2026,
• The Executive Director will discuss the results of the training with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

190b - Insulin Injections

27. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 12/26/2025 at 8 AM, staff person C, who has not successfully completed the Department-approved medications administration course, administered insulin to resident 13.

On 12/29/2025 and 12/5-12/7 at 12 PM, staff person E, who has not successfully completed the Department-approved medications administration course, administered insulin to resident 13.

Plan of Correction ***Accept ([redacted] - 02/12/2026)***

• Upon notification, all Medication Technicians with inaccurate observations or documentation were immediately removed from medication carts.
• Resident safety was protected by ensuring that only qualified and compliant staff administered medications while the identified individuals were removed from medication administration duties.
• Recertification training for the affected Medication Technicians was initiated immediately in accordance with regulatory requirements. Trainings conducted on 12/30/25 – 12/31/26 by a certified Train the Trainer for the DHS medication Administration Course.
• Medication Technicians did not return to medication carts or resume medication administration duties until all required recertification, competency validation, and authorization requirements were met.
• A Certified Medication Administration Train-the-Trainer proctored the recertification process, competency

190b Insulin Injections (continued)

validation, and authorization for return to medication administration duties.

• Diabetic management training was conducted on December 31, 2025, for seven Medication Technicians and on January 14, 2026, for an additional four Medication Technicians.

• The current clinical leadership team will be re educated on the requirements of 55 Pa. Code § 2600.190(b). Training will be conducted by the Executive Director or designee.

• Training will begin on February 1, 2026.

• All required training will be completed no later than February 18, 2026.

• Trainings will be documented on a Record of training

• The Health & Wellness Director or designee will conduct audits of resident medication administration records and staff training files to verify that only staff who have completed required diabetic and insulin administration training are assigned to administer insulin. Any discrepancies will be corrected immediately and reported to the Executive Director. Audits will be for 1 month and then monthly for 2 months beginning February 1, 2026, and concluding April 22, 2026.

• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

191 - Resident Right to Refuse

28. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident 3, admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept ([redacted] - 02/12/2026)***

• Upon notification by DHS, it was confirmed that prior to [redacted] the community's Resident Rights documentation did not explicitly include language addressing a resident's right to refuse medications.

• Residents who executed a residency agreement prior to the addition of the resident right to refuse medications will be provided with a Resident Rights Addendum that explicitly states this right.

• The addendum will be reviewed with the resident and/or designated representative and signed to acknowledge receipt and understanding.

• The current operations leadership team will be re educated on the requirements of 55 Pa. Code § 2600.191. Training will be conducted by the Regional Director of Operations.

• Training will begin on February 1, 2026.

• All required training will be completed no later than February 18, 2026.

• Training will be documented on a Record of Training.

• The Executive Director or designee will be responsible for distributing the addendum and collecting signed acknowledgments.

• Signed addenda will be maintained in the resident record to document compliance.

191 - Resident Right to Refuse (continued)

• Ongoing compliance will be maintained by incorporating resident medication rights education into the admission and care planning process, with documentation maintained in the resident record.
• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented (- 04/14/2026)

225c - Additional Assessment

29. 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 3's assessment, dated , does not include needs relating bowel and bladder management which is marked as "E- Not applicable", It also does not include needs for transferring and positioning. Resident 3 uses a bedside mobility device. The area of the assessment for social and recreation needs is also not completed in its entirety.

Resident 15's assessment, dated does not include bowel and bladder management these areas are marked "E- not applicable". As of the resident uses . It does also not include any needs for turning and positioning in a bed/chair, however under the need for transferring in/out of bed/chair the support plan list "[resident 15] requires frequent hands-on assistance with transfers and/or change in position. The resident uses a bedside mobility device. The area on the assessment for social and recreation needs is not filled out in its entirety.

Repeat violation: 9/18/2025

Plan of Correction ***Accept (- 02/12/2026)***

• Upon notification by DHS, it was identified that additional resident assessments were not completed accurately and in their entirety.
• It was also identified that Resident 15's assessment dated , did not accurately reflect the resident's needs.
• Resident safety was protected by confirming that each resident's current care needs, including bowel and bladder management, mobility supports, transferring, positioning, and social and recreational engagement, were being met appropriately at the time of review.
• The Resident Assessments and Support Plans were updated for resident #15 to ensure all sections are complete,

225c Additional Assessment (continued)

accurate, and reflective of each resident's current needs, including bowel and bladder management, use of mobility devices, transferring and positioning requirements, and social and recreational needs.

• The current clinical leadership team will be re educated on the requirements of 55 Pa. Code § 2600.225(c) related to completion of annual and updated assessments. Training will be conducted by the Executive Director or designee.

• Training will begin on February 1, 2026.

• All required training will be completed no later than February 18, 2026.

• Trainings will be documented on a Record of Training.

• Ongoing monitoring and compliance the Health & Wellness Director or Designee will conduct and audit to verify that current resident service plans reflect the current needs of the residents. Audits will be conducted for 1 month and then monthly for 2 months beginning February 1, 2026, and concluding on April 22, 2026.

• The results of the audits will be reviewed by the Executive Director or designee.

• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

227d - Support Plan Medical/Dental

30. Requirements

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

Description of Violation

The assessment for resident 3, dated [redacted] indicates the resident has a need for bed side mobility as of [redacted] The resident's support plan, dated [redacted] does not document how this need will be met.

When bedside mobility devices are being used, the Resident Support Plan must reflect:
The specific need for the device,
The intended Use,
Any risks associated with the device,
The resident's ability to use the device safely for the intended purpose,
Identification of the specific device to be used,
If a cover is required to meet FDA guidelines.

Plan of Correction ***Accept ([redacted] - 02/12/2026)***

• Upon notification by DHS, it was identified that the Resident Support Plan for Resident 3, dated [redacted] did not fully reflect the bedside mobility needs identified in the resident's assessment.

• Upon identification, the Resident support plan for resident #3 was reviewed and immediately updated to fully

227d - Support Plan Medical/Dental (continued)

document the use of a bedside mobility device.

• The updated Resident Support Plan was reviewed with applicable care staff to ensure understanding and consistent implementation.

• To prevent recurrence, the community reviewed current assessment and support plan documentation practices to ensure that all medical, adaptive, and mobility-related needs identified during assessments are accurately and consistently carried over into the Resident Support Plan in accordance with 55 Pa. Code § 2600.227(d).

• The clinical leadership team will be re-educated on the requirements of 55 Pa. Code § 2600.227(d), with emphasis on documenting medical services, adaptive equipment, and bedside mobility devices in the Resident Support Plan. Training will be conducted by the Executive Director or designee.

• Training will begin on February 1, 2026.

• All required training will be completed no later than February 18, 2026.

• Trainings will be documented on a Record of Training.

• Ongoing monitoring and compliance the Health & Wellness Director or Designee will conduct and audit to verify that current resident service plans reflect the current needs of the residents. Audits will be conducted for 1 month and then monthly for 2 months beginning February 1, 2026, and concluding on April 22, 2026.

• Monitoring will be completed by the Health and Wellness Director or designee.

• The results of the audits will be reviewed by the Executive Director or designee.

• The Executive Director will review monitoring outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

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

233c - Key-Locking Devices

31. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the doors to the Secure Dementia Care Unit (SDCU). Codes found posted near the doors were outdated.

Plan of Correction ***Accept ([redacted] - 02/12/2026)***

• Upon notification by DHS, it was identified that door access codes were posted above the door frame and not readily visible or accessible to residents and families.

• On December 31, 2025, all applicable door access codes were posted in a clearly visible location within a framed display to allow residents, families, and guests to enter and exit the community safely and independently.

• The current clinical leadership team and Plant Operations staff will be re-educated on the requirements of 55 Pa. Code § 2600.233(c). Training will be conducted by the Regional Director of Operations.

• Training will begin on February 1, 2026.

• All required training will be completed no later than February 18, 2026.

• Trainings will be documented on a Record of Training

• Ongoing compliance will be monitored through weekly supervisory review to ensure posted access codes remain

233c - Key-Locking Devices (continued)

current, visible, and accessible.

• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented (- 04/14/2026)

234a - Admission Support Plan

32. Requirements

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 4 was admitted to the Secure Dementia Care Unit (SDCU) on . However, the resident's initial support plan was completed on

Plan of Correction ***Accept (- 02/12/2026)***

• Upon review, it was determined that the Admission Support Plan for Resident 4 was not completed within the required 72-hour timeframe following admission to the Secure Dementia Care Unit (SDCU).

• The resident's Support Plan has since been reviewed by the Health and Wellness Director to ensure it accurately reflects the resident's assessed needs and services provided. .

• The community reinforced internal admission processes to ensure that Admission Support Plans for the Secure Dementia Care Unit are developed, implemented, and documented within 72 hours of admission in accordance with regulatory requirements. The current clinical leadership team will be re-educated on the requirements of 55 Pa. Code § 2600.234(a). Training will be conducted by the Executive Director or designee.

Training will begin on February 1, 2026.

All required training will be completed no later than February 18, 2026.

• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented (- 04/14/2026)

252 - Record Content

33. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.

252 - Record Content *(continued)*

5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident 2's record does not include a copy of the official death certificate. Resident 2 passed away [redacted]

Plan of Correction ***Accept ([redacted] - 02/12/2026)***

• Upon notification by DHS, it was identified that the community did not have a copy of the death certificate on file for a resident #2, who expired [redacted].

• Upon identification of the issue, the community initiated efforts to obtain the resident's death certificate from the appropriate source and received a copy on January 12, 2026 by the Health and Wellness Director.

• Resident dignity and compliance were protected, as required post-death procedures were followed at the time of the resident's passing.

• The death certificate will be maintained in the resident record upon receipt to document compliance.

• The current clinical leadership team will be re-educated on the requirements of 55 Pa. Code § 2600.252. Training will be conducted by the Executive Director or designee.

• Training will begin on February 1, 2026.

• All required training will be completed no later than February 18, 2026.

• Trainings will be documented on a Record of Training

• Ongoing compliance will be monitored through monthly supervisory review of closed resident records to verify that as applicable a death certificate is part of the closed record for three months beginning February 1, 2026, and concluding May 1, 2026.

• Monitoring will be completed monthly by the Executive Director or designee.

252 - Record Content (continued)

• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on March 11, 2026.

Licensee's Proposed Overall Completion Date: 02/18/2026

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