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

June 10, 2026

[REDACTED], ADMINISTRATOR
LEGACY AT BRISTOL INC

RE: LEGACY GARDENS OF BRISTOL
2022 BATH ROAD
BRISTOL, PA, 19007
LICENSE/COC#: 13108

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/05/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LEGACY GARDENS OF BRISTOL* **License #**: *13108* **License Expiration**: *02/13/2026*

Address: *2022 BATH ROAD, BRISTOL, PA 19007*

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

Administrator

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

Legal Entity

Name: *LEGACY AT BRISTOL INC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/18/2010* **Issued By**: *Bristol Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *28* **Waking Staff**: *21*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *01/05/2026*

Inspection Dates and Department Representative

01/05/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served**: *24*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *24*

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

Have Mobility Need: *4* **Have Physical Disability**: *0*

Inspections / Reviews

01/05/2026 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/01/2026*

02/12/2026 - POC Submission

Submitted By: **Date Submitted**: *03/16/2026*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/16/2026*

Inspections / Reviews *(continued)*

02/27/2026 POC Submission

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

Reviewer: [REDACTED] **Follow Up Type**: *Document Submission* **Follow Up Date**: *03/18/2026*

06/10/2026 Document Submission

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

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

16c - Written Incident Report

1. Requirements

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

Description of Violation

On [redacted] the home contacted the police to report resident 1 left the premises with an unknown individual. Police arrived at the home shortly thereafter. The home did not report the incident to the department until [redacted]

Repeat violation: 1/3/2025

Plan of Correction ***Accept ([redacted] - 02/26/2026)***

To correct this violation the Director has added to the front of our reportable incident book the words "within 24 hours" these words have also been added to the board where we posted the list of reportable incidents and to the Master Reportable incident form. Photos were taken to show this step.
Additionally, a training was held on 2/13/2026 covering the regulation (2600.16c) regarding the timeframe for reporting reportable incidents as well as types of incidents that are reportable. The Executive Director, Director of Resident Care and our Floor Supervisor attended the training taken from the Regulatory Compliance Guide.
Daily Morning meetings to review events from the previous 24 hours will be discussed to identify any possible reportable incidents. This began today 2/13/2026 and will be daily ongoing. It will be the responsibility of the Manager on duty to initiate these morning meetings.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented ([redacted] - 06/10/2026)

17 - Record Confidentiality

2. Requirements

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

Description of Violation

On 1/5/2026 , at 9:00 AM, resident's medical information and medications were unlocked, unattended, and accessible in the medication closet next to the front office.

At 9:48 AM a binder containing resident shower schedules was unlocked, unattended, and accessible in the laundry room.

At 9:52 AM resident records and medical information unlocked, unattended, and accessible laying in piles on the floor of the unlocked office.

17 Record Confidentiality (continued)

Plan of Correction ***Accept (- 02/26/2026)***

In response to this violation the Director has placed a Notice on the Medication Station door reminding all that the doors are to be closed and locked when the shift's med tech is not actively working at that location Our medication keys have been put on a lanyard and the med tech on duty is responsible for the keys until the end of the shift.
The shower schedule for both the East and West sides of Legacy Gardens are now listed by Room numbers only. All names have been removed by the floor Supervisor,
The resident information to be destroyed has been moved from the office floor and is now and will ongoing be kept in a locked drawer in the office until they are destroyed. A list containing resident room numbers for care needs will be kept inaccessible to residents as a person can easily discern which resident is being identified by their room number. The Director and DRC are responsible for this.
Training was held at our staff meeting on 1/29/2026 by the Executive Director and Director of Resident Care regarding this violation and our other deficiencies. A discussion was held about maintaining the confidentiality of resident information by our Floor Supervisor with all staff who attended the meeting. Staff who were unable to attend the scheduled meeting were given a hand out of the meeting agenda. The Floor Supervisor reviewed the agenda with the staff person. All staff signed in to the meeting or signed an acknowledgement that the agenda had been reviewed with them.
A weekly audit of all areas will be done by the floor supervisor to ensure no personal information is accessible.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (- 06/10/2026)

26a - Quality Management Plan

3. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home does not have a quality management plan.

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

Legacy Gardens previously held our quality management program along with our safety meeting. It was handled with a two page checklist, checked monthly in all departments, maintenance, housekeeping, dietary, administrative, regulatory and resident feedback taken from the resident meetings.
Our quality management program will now be held separately at Legacy Gardens each quarter of the year with any resident complaints responded to within 24 to 48 hours.
A copy of this 2026 plan will be provided upon approval.
Meetings with the Quality Management team will be scheduled by the Director..

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented (- 06/10/2026)

65e - 12 Hours Annual Training

4. Requirements

2600.

65e - 12 Hours Annual Training *(continued)*

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A's amount of annual training hours for 1/1/2025-12/31/2025 can not be determine because the home's record of training does not include the length of each training.

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

We will now use the state form for the Annual Training Plan and fill in the times on the designated column. For group trainings, we will use the state Training Record which also has a designation place for time.
Previously we used our company individual Training tracker and a column for total annual training hours per employee has been added..
The Executive Director and/or Director of Resident Care will be responsible for the annual plan, record and Training tracker documentation.

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented (- 04/06/2026)

65f - Training Topics

5. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in medication self-administration training and personal care service needs of the resident during training year 1/1/2025-12/31/2025.

Repeat violations 1/3/2025

Plan of Correction ***Accept (- 02/26/2026)***

The training plan for Legacy Gardens Direct Care Staff and other employees in 2026 (January through December) now contains all of the State Licensing / Mandatory annual trainings to ensure compliance with this regulation. Any other trainings completed will be kept separately to avoid confusion. The Training Plan for the year was done by the Executive Director, Director of Resident Care and will be monitored monthly by the Floor Supervisor for compliance. The staff person indicated has received the training on medication self-administration as of 2/13/2026. An additional audit of the staff training records for 2025 is being done by the director and any staff found to be missing trainings will receive the necessary education to bring them complaint. This audit will begin 2/14/2026 and should be completed by2/28/2026.
Ongoing quarterly reviews will be done by the Floor Supervisor of staff training records in comparison to the

65f Training Topics (continued)

annual Training Plan to identify any staff not up to date with the trainings for the current year. If any deficiency is identified the staff person will be given the education needed to bring them compliant.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (- 04/06/2026)

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 B did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations during training year 1/1/2025 to 12/31/2025.

Plan of Correction ***Accept (- 02/26/2026)***

In response to the violation on 01/05/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 01/27/2026 by the Director and Director of Resident Care to review the training topics (65f), and the training content (65g) on the Training plan. The Training Plan for the Direct Care staff and all other employees now contains all of the state licensing mandatory annual trainings to ensure compliance with this regulation. This is document on the Training Plan and our individual training tracker. All other trainings (not mandated) will be recorded separately to ensure ALL staff are appropriately trained each year. The Director and Director of Resident Care will be responsible to monitor and document the trainings as they as they occur. Staff person B, on review of 2025 training records, had no other missing mandated trainings. Additional audits of all employee files to ensure they have received trainings should be completed and any staff found to be missing trainings will receive education to bring them compliant. These audits will begin 2/14/26 and should be completed 2/28/26. The audits will be done by the Floor Supervisor. Ongoing training record audits will be done quarterly in comparison to the annual staff training plan by the Floor Supervisor in 2026 to identify staff who may be not up to date with the trainings for the current year. Any staff identified as not being up to date will be given the education to bring them compliant.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (- 04/06/2026)

65i - Training Record

7. Requirements

2600.

65i - Training Record *(continued)*

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 training does not include length of each course.

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

Legacy Gardens is now using the state form to record trainings. All columns are filled out including number of clock hours for each training. The Director of Resident Care and the Executive Director will be responsible for this complete documentation as the trainings occur.

Licensee's Proposed Overall Completion Date: *01/27/2026*

Implemented (█ - 04/06/2026)

85a - Sanitary Conditions

8. Requirements

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

Description of Violation

On 1/5/2026 at 9:19 AM, there were 3 cracked eggs on a plate, and a used glove sitting on the counter next to partially covered frozen pancakes and waffles that were warm to the touch.

At 9:30 AM in resident 2's room's there was food crumbs on the floor outside the bathroom. The bathroom smelled like feces and streaks of feces were visible on the walls and floor near the door.

At 9:37 resident 3's room smelled heavily of urine. There was a used brief in the resident's bathroom trash can. In the bathroom there was no method to dry hands.

At 9:44 AM in resident 4's bathroom room there was feces smeared on the wall and handrail.

At 2:46 PM in a shared room bathroom of bedroom 23 that shared by 2 residents, there was no method to dry hands. 4 unlabeled loofahs of various colors were in the shared shower.

Plan of Correction ***Accept (█ - 02/26/2026)***

85a - Sanitary Conditions (continued)

To enhance the currently compliant operations, on 02/14/2026 the Director of Resident Care and Executive Di will review the RASPS of the residents named and found the root cause of the violation regarding resident #2 is that ■ is no longer able to stand even with assistance for the length of time needed to take care of ■ toileting needs. ■ assessment and support plan will be amended to address this change. Direct Care staff will now do the residents changes in ■ bed to resolve the sanitation issues. Resident #4 , root cause was determined to be that this resident , because ■ is still mobile, believes ■ can independently care for ■ cognitive ability says ■ needs assistance when toileting for cleanliness reasons. ■ RASP will be amended to address this need. Direct Care staff will now follow a 2-hour toileting schedule for this resident so that assistance will be provided. In March 2026 all direct care staff will have training on "Change in condition" of a resident and how frequent reviews of a residents' care plan will address these changes or, if there is a need that is not on the care plan it needs to be reported to the Director of Resident Care, with a completion date of 03/31/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (■ - 06/10/2026)

96a - First Aid Kit

9. Requirements

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

Description of Violation

The home's first aid kit does not include a breathing shield.

Plan of Correction ***Accept (■ - 02/26/2026)***

In response to the violation on 01/05/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 01/29/2026 by the Floor Supervisor to address the fact that our breathing shields are too large to fit in our first aid kit. The floor supervisor put the first aid kit, and the breathing shield in a tote together. The tote is now located in an unlocked closet that is available to all staff but in an area that is not accessible to our residents. This information has been relayed to all staff at the staff meeting held 1/29/2026.
Effective 02/14/2026 the Floor Supervisor will perform monthly checks for compliance with location and contents. Any supplies needed or if a change in location is needed, this will be reported to the Director through 12/28/2026 to maintain ongoing compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (■ - 04/06/2026)

96c - First Aid Accessible

10. Requirements

2600.
96.c. The first aid kit must be in a location that is easily accessible to staff persons.

Description of Violation

The home's first aid kit is located in the locked medication closet. This closet is not always accessible to staff because not all staff have keys to the closet. No staff person has keys to the closet during the 3 PM to 11 PM shift.

96c First Aid Accessible *(continued)*

Plan of Correction ***Accept (- 02/26/2026)***

In response to the violation on 01/05/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 01/29/2026 by the Floor Supervisor to place the breathing shield as well as the first aid kit in a tote together. The tote was then placed in an unlocked closet that is accessible to all staff but in an area that is not accessible to our residents. All staff were given this information at the all staff meeting on 1/29/2026.

Effective 02/14/2026 the Floor Supervisor will perform monthly checks of to ensure compliance as to location and contents of the kit. Any deficiencies as to either location or content will be noted and reported to the Director, through 12/28/2026 to maintain ongoing compliance with locating the first aid kit in a location that is easily accessible to staff persons. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (- 04/06/2026)

102i - Soap Dispenser

11. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 1/5/2025 at 9:44 AM there was no hand soap located in the bathroom of resident 4.

Plan of Correction ***Accept (- 02/26/2026)***

In response to the violation on 01/05/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 01/06/2026 by the Floor Supervisor to provide resident #4 ,who is in a private room, a bar of soap to wash hands.

To enhance the currently compliant operations, on 02/01/2016 the Director will generate a letter to send to each responsible party letting them know that it is a regulation that a dispenser with soap be within reach of the resident's sink. Legacy Gardens provides dispensers for the common area bathrooms. The letter will also state that it is prohibited to have a bar of soap in the shared rooms as they cannot be labeled once opened, with a completion date of 02/02/2026.

Effective 02/14/2026 the Floor Supervisor will perform weekly checks of resident bathrooms to ensure that all residents have required items are present and accessible to residents to maintain proper sanitation., through 12/31/2026 to maintain ongoing compliance with providing a dispenser with soap within reach of each bathroom sink, and to not permit bar soap unless there is a separate bar clearly labeled for each resident who shares a bathroom. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (- 06/10/2026)

103i - Outdated Food

12. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was an unlabeled and undated cereal in plastic containers on a cart in the dining area.

In the main refrigerator there were 2 unlabeled and undated containers of beef stew. One of the containers was unsealed. There were also 3 jimmy dean brand breakfast packages on the top self with a label that read "Keep frozen until use"

In the freezer there was unsealed, unlabeled and undated bowl of strawberry ice cream.

Plan of Correction ***Accept ([redacted] - 02/26/2026)***

In response to the violation on 01/05/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/02/2026 by the Cook to remove food items in violation.

To enhance the currently compliant operations, on 01/29/2026 the cook will do a daily check of all areas where food is stored, prepared and served. Once compliance is consistent, the checks will be done weekly, with a completion date of 12/28/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented ([redacted] - 04/06/2026)

105g - Lint Removal and Duct Cleaning

13. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 1/5/2025 at 9:48 AM, there was an approximate 1/4-inch accumulation of thick gray lint in the lint trap of the dryer. There were no clothes in the dryer at the time.

Plan of Correction ***Accept ([redacted] - 02/26/2026)***

In response to the violation on 01/05/2026 by the Pennsylvania Bureau of Human Service Licensing, action was taken on 02/02/2026 by the Maintenance to check all lint traps for accumulation of lint and remove from trap if found. Maintenance will report results of daily lint trap checks to the Director. Staff were informed of this problem and reminded of the importance of checking lint traps after every drying session due to the hazard of fires. This was discussed and documented at the staff meeting on 1/29/2026. the Training was done by the Director.

105g Lint Removal and Duct Cleaning (continued)

Effective 01/05/2026 the maintenance person will perform checks on all lint traps for accumulation of lint and removal if found, through 12/28/2026 to maintain ongoing compliance with reducing the risks of fire hazards by removing lint from lint traps and drums of clothes dryers after each use, and to ensure lint is cleaned from vent ducts and internal and external ductwork of clothes dryers according to the manufacturer's instructions. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (█ - 04/06/2026)

125a - Combustible Storage

14. Requirements

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

Description of Violation

On 1/5/2026 at 9:19 AM a can of PAM cooking spray with a label reading "Keep away from heat, hot surfaces, sparks, open flames, and other ignition sources. No smoking" and a paper towel were sitting on the oven top which was warm to the touch.

At 10:08 AM a jug of urine remover spray and an old phone book were sitting on top of the forced air heater which was warm to the touch. On the side of the heater there were cardboard boxes leaning against it and a cushion jammed between the heater and metal cabinet.

Plan of Correction ***Directed (█ - 02/26/2026)***

All combustible and flammable materials were immediately removed from heat producing surfaces including the oven top and forced air heater. This was done 1/5/2026. Staff were re educated on proper storage requirements and reminded that no items may be placed on or within 3 feet of heat sources. This education was provided by the Director on 1/29/2026. Storage areas were reorganized to ensure cleaning products, paper goods, and cardboard are kept in approved locations away from ignition sources on 01/07/2026.
Maintenance conducted an inspection of heating units to ensure surrounding areas remain clear. on 01/07/2026
Supervisors will complete weekly safety rounds beginning 1/13/2026 to monitor compliance.
Facility Director and Maintenance Supervisor will be responsible for doing these rounds weekly until the last week of the year.

Directed Completion Date: *02/26/2026*

Implemented (█ - 06/10/2026)

132b - Safety Inspection/Fire Drill

15. 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.

132b - Safety Inspection/Fire Drill *(continued)*

Description of Violation

The last fire safety inspection observed by a fire safety expert was conducted on 7/11/2025. The prior inspection was completed on 4/25/2024.

Plan of Correction ***Accept (- 02/26/2026)***

The fire inspection at Legacy Gardens in 2025 was done July 11th. This date has been noted on the maintenance checklist and the office calendar. The maintenance person will call the local fire marshal in June 2026 to schedule an appointment for this year's fire inspection
before July 11, 2026.

Ongoing, the date of the fire inspection will be noted by maintenance and administration to ensure compliance with regulation 2600.132b.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (- 06/10/2026)

141b1 - Annual Medical Evaluation

16. Requirements

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

Description of Violation

Resident 2's most recent medical evaluation was completed on

Plan of Correction ***Accept (- 02/26/2026)***

The physician was given a calendar of when the med eval is due and the form was faxed to office. Despite numerous phone calls, we could not reach this Doctor. After the inspection, the family of this resident was able to get Drs new phone number and fax and we now have the signed DME.

Going forward, this Dr's office has given us a direct phone number so that we can communicate this resident's needs. Director of Resident Care will send the DME a week earlier to allow ample time for return of form to keep us in compliance.

Current resident files were immediately audited by the Director of Resident Care to ensure no DME was missed or missing information.
All due dates for DMEs and RASPs are not plotted on our large office calendar for all office staff to see. Going forward, the DRC, Executive Director and Floor Supervisor all have access to the Calendar and will be responsible for ensuring the completeness of documentation needed. The DME form will be sent to the appropriate physician two weeks before the due date. This process was begun January 2026. Monitoring of the completeness will be done by the Director of Resident Care, Executive Director and Floor Supervisor. as soon as each DME is returned to Legacy Gardens.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (- 04/06/2026)

144c2 - Smoking Area Distance

17. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The home's designated smoking area is located on the back porch. However, on 1/5/2026 this area contained cushions that were not flame retardant, and cardboard boxes of Christmas ornaments.

Plan of Correction ***Accept (█ - 02/26/2026)***

In response to the violation on 01/05/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 01/06/2026 by the Maintenance to remove all cushions from the smoking area. Aii staff, including smokers were re-educated regarding our smoking area location and the need to keep this area free of cigarette butts and combustible materials. It was stressed at the training that safety is everyone's responsibility! The training took place on 1/29/2026 at the staff meeting regarding our inspection on 1/5/2026. A sign was posted on 01/29/2026 in the smoking area to remind everyone that cigarette butts belong in the fire safe container and that no combustible materials can be stored or placed temporarily in this area. Our one current resident smoker was addressed by the Director of Resident Care about the smoking area policy and reminded of the need for everyone to monitor the safety
of Legacy Gardens on 1/30/2026.

Effective 01/29/2026 Maintenance will perform daily audits until compliance is consistent, then weekly audits of smoking area. The smoking area will be checked for cigarette butts being in the proper containers, no combustible materials located there and general neatness of the area., through 12/31/2026 to maintain ongoing compliance with this regulation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (█ - 06/10/2026)

162d - Past Menus

18. Requirements

2600.
162.d. Past menus of meals that were served, including changes, shall be kept for at least 1 month.

Description of Violation

For supper on 1/4/2026 beef stew was substituted for sloppy joes. The home does not keep a record of past menus and changes made.

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

Our menu changes are usually written on sticky notes and attached to the menu date and time. Ongoing a plastic sleeve will be behind the current menu to put that week's menu with changes in to keep at least for one month. Our Lead cook will be responsible for saving the menus.

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

162d - Past Menus *(continued)*

Implemented (- 04/06/2026)

181c - Self-administration Assessment

19. 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 5 self-administers medications to include gabapentin 600 mg tablets; however, resident 5 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 (- 02/26/2026)***

Resident self-administration of medications happens if the resident requests to do so and their DME supports this request. If not, we contact the resident's physician and ask if an evaluation and determination can be done as the resident wants to self-administer.

This resident was assessed for self-administration at request. The physician wrote an order stating could administer own medications. The order was not attached to the DME at the time of inspection but was on chart under physician orders.
Ongoing the. Director of Resident Care will check the files of any resident who is requesting to self-administer to verify the physician's permission. This will be at the time of the resident's request.

Residents who self- administer are assessed monthly by the DRC to verify meds are being taken as per the physicians' order and that we have a current list of medications taken.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (- 06/10/2026)

181f - Record of Medication

20. 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 1/5/2026, resident 5's record did not include a current list of medications. The list in the resident's record did not include APAP/codeine 300-30 mg tablets.

Plan of Correction ***Accept (- 02/26/2026)***

This resident uses a different pharmacy than all other residents living at Legacy Gardens. The resident was reluctant to give any information regarding the pharmacy. After our inspection we checked the label on a medication ordered by the resident and called the pharmacy. We now have a list of this resident's meds on file.
Monthly the DRC will meet with this resident to verify any changes with the resident and medications. A

181f Record of Medication (continued)

checklist documenting this meeting will be with ██ MAR. These monthly meetings will occur the first week of each month for any resident of Legacy Gardens who self administers medications.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (██ - 06/10/2026)

183a - Original Containers and Injections

21. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On 1/5/2026 at 9:00 AM, hydralazine 25 mg tablet for resident 7 was in in a pill cup on the medication closet. This medication was not scheduled for administration until 12:00 PM.

On 1/5/2026 at 9:00 AM, Carb/Levo 25 100 mg tablet for resident 7 was in in a pill cup on the medication closet. This medication was not scheduled for administration until 2:00 PM.

Plan of Correction ***Accept (██ - 02/26/2026)***

The med tech poured this resident's medications at the time ██ came to breakfast. At that time, ██ noted ██ was to take meds two other times during the shift and poured these meds in two separate cups as reminders. Ongoing we will place the empty med cups with times written on them as reminders. All med staff have been notified of the above, and a reminder is posted at the med station by the DRC.
All staff qualified to administer medications received training about not pre pouring medications on January 12, 2026.
The Director of Resident Care and /or the Practicum observer will monitor med techs at random times weekly at first and when compliance is consistent will monitor monthly, Monitoring will begin 02/14/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (██ - 04/06/2026)

183b - Meds and Syringes Locked

22. 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

On 1/5/2026 at 9:00 AM, all medications for residents of the home were unlocked, unattended, and accessible in an unlocked medication closet.

At 9:30 AM nystatin powder and polymyxin B/TMP eye drops were found unlocked, unattended, and accessible in an

183b Meds and Syringes Locked (continued)

unlocked resident 2's bedroom. Over the counter Aleve, extra strength Tylenol, and Daytime/ Nighttime Assured multi symptom capsules were unlocked, unattended, and accessible in an unlocked in resident 2's bathroom.

At 10:04 Bumatoprost Ophthalmic solution was found unlocked, unattended, and accessible in resident 8's bedroom.

At 2:43 PM a loose white pill was found unlocked, unattended, and accessible on top of the dresser of resident 6.

At 2:43 PM, there were several unlocked, unattended medications to include Pepto Bismol and enalapril maleate 5 mg tablet in a bedside table belonging to resident 5. This room is shared with resident 6, who is not capable of self administering medications. The door to the shared room was also observed to be open at the time.

Plan of Correction ***Accept (- 02/26/2026)***

All med techs on duty are responsible to have the keys on their person and must lock the med doors when walking away for any reason. All med techs are aware and at the staff meeting on January 29th, 2026, all staff were reminded that we are a team so all of us must look out for one another and "cite what we see" either by reminding the person responsible or correcting the issue ourselves.
All medications found in resident rooms were removed immediately and families were made aware by letter sent 2/01/2026 that medications they bring in must be given to the DRC and not left with a resident. The DRC will obtain an order from the physician if needed and the labelled med will be stored at the med station. Staff were reminded as well at the staff meeting 1/29/2026, that if they come across any medication in a resident room or bathroom, the DRC must be notified.

Our floor supervisor checks resident rooms daily and has added this medication storage issue to checks to ensure ongoing compliance. This will begin 2/14/2026.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (- 06/10/2026)

183d - Prescription Current

23. 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 1/5/2026, polymyxin B/TMP eye drops prescribed for individual resident 2, was in the home; however, the medication was discontinued on 10/2/2025.

Plan of Correction ***Accept (- 02/26/2026)***

The DRC called the pharmacy regarding this reg. and the violation; The Pharmacy sent a technician to Legacy Gardens. The tech reviewed all residents' meds and removed all expired or discontinued meds and stated will do this on a quarterly basis. left handouts for all med staff as to the expiration dates of all forms of meds and provided yellow stickers to place on original containers to write start and end dates for all meds. also left an Inservice training on Med cart auditing for us.

All staff qualified to administer medications on1/20/2026 were trained on checking medication expiration dates prior to administering the med and removing and reporting any expired medication to the Director of Resident Care. It

183d Prescription Current (continued)

was discussed that if a medication has been discontinued the med techs should check to be sure it has been removed from the med station and given to the Director of Resident Care.
A weekly check by the Director of Resident Care and or the Practicum Observer of the medications to check for proper storage, expired medications, discontinued medications, and sanitation will be done, The weekly reviews will begin 2/16/2026 and will be initialed on the MAR sheet at the front of the medication record Binder.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (- 06/10/2026)

183e - Storing Medications

24. 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 1/5/2026, a container of over the counter Aleve was found in resident 2's bathroom cabinet. This medication expired 9/2020.

The following expired medication was found in the narcotic box at room temp:

- *Resident 3's morphine 5 mg, give one syringe every 4 hours as needed for pain which expired 10/1/2025.*
- *Resident 9's lorazepam .25 ml take one syringe by mouth every 4 hours as needed for anxiety. Refrigerate. This medication was not refrigerated and expired on 12/21/2025.*
- *Resident 10's lorazepam .25 ml take one syringe by mouth every 4 hours as needed for anxiety. Refrigerate. This medication was not refrigerated and expired on 8/14/2025.*

Resident 11's blister pack of lorazepam .5 mg had the foil completely removed at slots 23 and 15. The pills remained inside the compartments stuck to clear scotch tape.

Plan of Correction

Accept (- 02/26/2026)

The expired meds were taken care of by the pharmacy technician as above. and have been destroyed and replaced in the med station.
Meds to be refrigerated have been identified by the pharmacy technician and is included in the handouts left. Our Medication refrigerator has been moved into the med station, meds needing refrigeration are placed inside and the refrigerator will be locked.
Resident 11's medications go home with when an extended leave. was not aware that meds must be removed in order and cannot be placed back in the slot if the resident does not take them. The DRC and Director have spoken to the resident's regarding the above and agreed to comply. The Pharmacy has provided blister pack well resealers to secure the medications in the blister packs. (these have been sent back to the pharmacy so they will NOT be used)

183e - Storing Medications (continued)

All Staff qualified to administer medications were trained January 29, 2026, on checking expiration dates prior to administering the med and removing and reporting any expired to the Director of Resident Care. the training included discontinued meds being removed from the med station and given to the DRC. Staff were also informed on storing liquid lorazepam in the locked refrigerator.
A weekly check by the DRC and/or Practicum Observer of the medications to check for proper storage, expired meds, discontinued meds and sanitation will be done beginning 2/16/2026. The checks will be initialed on the MAR sheet at the front of the medication record binder.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (█ - 06/10/2026)

185a - Implement Storage Procedures

25. 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 1/5/2026, the home's-controlled substances were kept in an unlocked filing cabinet in the medication closet. The home's-controlled substance policy states "medications listed as schedule II are stored under double lock in a locked cabinet or safe separate from all other medications".

The home administers Apap/Codeine Tab 300-30 mg "take one tablet every 4 hours as needed" to resident 5. The home keeps only a controlled substance log for this medication and not a medication administration record. Between 1/3/26 at 5 AM and 1/4/26 at 3 PM there is a line that has no signature. Only a "19" on hand and "18 remaining" no date, time or name of person who removed the medications can be found for pill 19 The home's medication policy is "11: Record each medication administered by initialing the MAR".

Resident 11's controlled substance accountability log for lorazepam .5 mg, take one tablet every 12 hours as needed for anxiety indicated there were 20 pills remaining, however there were 21 pills remaining in the blister pack.

Resident 12's controlled substance accountability log for morphine sul sol 100/5ML syringes indicated there were 22 syringes remaining, however there were 24.

The home's medication policies are "At each shift change or anytime narcotic key change, a physical inventory of schedule II controlled mediation is conducted by two medication trained staff and is documented on the controlled substances accountability log. Any discrepancy in controlled substance medication counts is reported to the director or resident care immediately. the director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies."

Plan of Correction ***Directed (█ - 02/26/2026)***

A training was scheduled and held on January 12, 2026, for all medication staff to reiterate the importance of the medication count and the reporting of any discrepancies to the DRC or Director. Ongoing the morning shift med tech will do a check of the previous days' count to ensure the checks are done properly and the count is correct.
The Medication and Controlled substance policies will be reviewed and updated on March1, 2026, by the Director of Resident Care to reenforce compliance with 2600 regulations. These changes will also be overseen by the Executive

185a - Implement Storage Procedures (continued)

Director and our corporate office.
A full medication audit will be done monthly when the pharmacy sends new MARS, to ensure that any medication that has a controlled substance, but is not listed on the MAR, is listed on the MAR correctly, that it is being initial as administered according to regulation, and that staff are following the homes policies for controlled substances. A training that includes the homes policies on medication and controlled substances will be scheduled for all staff who have successfully completed the training course to administer medications at Legacy Gardens
Ongoing the Practicum observer will; audit the MARS weekly until compliance is consistent and then will do monthly compliance checks.
Any deficiencies will be reported to the Director and Director of resident care so corrections can be done.

Directed Plan of Correction: *In addition to the above plan of correction, all staff qualified to administer medications shall be in-serviced on the updated policies within 5 business days of the completion of the review and update of the medication policies that is to be completed by 3/1/26.*

Directed Completion Date: *02/26/2026*

Implemented (█ - 06/10/2026)

187a - Medication Record

26. Requirements

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

Description of Violation

Resident 5 is prescribed Apap/Codeine Tab 300-30 MG which is administered by the home. However, the home does not keep a medication administration record for resident 5.

Repeat violation 1/3/2025

Plan of Correction ***Directed (█ - 02/26/2026)***

A MAR is now in place and will be used to document the administration of the narcotic we give to this resident.
Ongoing the pharmacy will provide a MAR for any resident who self-administers medication if we also administer medications for the resident. The DRC is responsible to notify the pharmacy if a resident is assessed as being able to self-administer their meds.
In March 2026 a training for all staff qualified to administer meds and the topic concerning regulation 2600.187.a and need for a MAR for all residents who are ordered medications and the need to report, if this is not the case, and a MAR is missing.
Medication policies will be reviewed March 1, 2026, by the DRC to reenforce compliance with the 2600 regulations. Any changes made will be overseen by the Executive Director and Corporate office as well.

Directed Plan of Correction: *In addition to the above plan of correction, all staff qualified to administer medications shall be in-serviced on the updated policies within 5 business days of the completion of the review and update of the medication policies that is to be completed by 3/1/26.*

Directed Completion Date: *03/01/2026*

Implemented (█ - 04/06/2026)

187b - Date/Time of Medication Admin.

27. Requirements

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

Description of Violation

Resident 11 is prescribed tramadol tablet .5 mg take by mouth every 6 hours as needed. Resident 11's 12/2025 and 1/2026 medication administration record does not include the initials of the staff person who administered this medication on 12/28/2025 at 9p, 12/29/2025 at 5p, and 1/2/2026 at 5p.

Plan of Correction ***Directed (- 02/26/2026)***

This occurred because had taken the resident and medication to their home. has agreed to remove medications in succession when they have them ongoing. This information was shared with the med techs at the time of the training Inservice on January 29, 2026.
resident 11 took for a couple of days and took medications with them in the blister pack. Upon the resident's arrival back to Legacy Gardens, the tramadol was not taken out of the blister pack in proper succession, therefore staff did not properly document what occurred. During our meeting in March 2026, new instructions will be given to all med staff that if takes a resident with a controlled substance, the blister pack must be returned intact, and when dispensing a med from the pack, they
must initial time and date and record on paper and send this documentation back with the resident. The paper will then be attached to the resident's MAR to ensure proper documentation. The DRC must inspect the blister pack and documentation upon the resident's return to the facility.

Directed Plan of Correction: *In addition to the above plan of correction, all staff qualified to administer medications shall be in-serviced on the updated policies within 10 calendar days of the completion of the review and update of the medication policies that is to be completed by 3/1/26. Additionally, medication technicians will immediately begin to accurately document on a residents MAR if a medication was administered by them, if the resident did not receive a medication due to refusal or leave of absence, hospitalization or with a notation for another reason the medication was not administered. The documentation from may be kept with the residents MAR however staff must be reviewing and accurately documenting their administrations and non-administrations including the reason for the non-administration directly on to the residents Medication Administration record.*

Directed Completion Date: *02/26/2026*

Implemented (- 06/10/2026)

28. 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 1/5/2026 at 9:00 AM, resident 7's Hydralazine 25 mg tablet was signed out as administered at 1/5/2026 12:00 PM and Carb/Levo tab 25-100 mg was signed out as administered at 2:00 PM. The resident had not yet received these medications; the medications were observed pre-poured in a medication cup in the unlocked medication cabinet.

Repeat Violation 1/3/2025

Plan of Correction ***Directed (- 02/26/2026)***

The med tech poured this resident's medications at the time came to breakfast. At that time, noted was to take meds two other times during the shift and poured these meds in two separate cups as reminders. Ongoing we

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

will place the empty med cups with times written on them as reminders. All med staff have been notified of the above, and a reminder is posted at the med station by the DRC.
In addition to our planned Medication Staff meeting in March 2026, staff will be educated about proper MARS documentation as well as NOT pre-poring medications more than one hour before the medications are to be given.

Directed Plan of Correction: *Within 10 calendar days of the homes medication policies being updated, all staff qualified to administer medications will receive education on the proper documentation for medication administration, including how and when to notate missed medications, non-administration of a medication, refusal of a medication etc.*
Additionally, the administrator or designee shall audit all resident MARS once a week for 4 weeks, then every other week at least, to ensure that medication staff are accurately documenting on the MAR's.

Directed Completion Date: *02/26/2026*

Implemented (- 06/10/2026)

190c - Record of Training

29. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person A does not include documentation of successful completion of the training.

Plan of Correction ***Accept (- 02/26/2026)***

Staff person A was trained by the Director when the Director was the Trainer. At that time, we did not know about the user report and thus did not print it out. As I am no longer the trainer, I no longer have access to training reports. I do have initial training reports from the year as well as user report from training as a Practicum Observer and will send them on approval.
All current qualified medication administration records will be checked to be sure the user report is available.
Ongoing our Practicum Observer will assure that all new medication trained staff have the user report before allowing them to administer meds. The user reports will be kept in the medication binder where the med persons observations and MARs reviews are kept.
The medication training records will be monitored monthly by the Director to ensure compliance is maintained.

Licensee's Proposed Overall Completion Date: *02/26/2026*

Implemented (- 04/06/2026)

224a - Preadmission Screen Form

30. 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 3 was admitted to the home on

224a - Preadmission Screen Form (continued)

; however, the resident's preadmission screening form was not completed.

Resident 5 was admitted to the home on [redacted] however, the resident's preadmission screening form was not completed.

Plan of Correction ***Accept ([redacted] - 02/27/2026)***

A packet has been made up for new admissions including the pre-screen, med evaluation form, and RASP forms so that all forms will be completed in a timely manner and not overlooked. The packets are now with our move in paperwork. This was done by the Director and DRC on February 17, 2026.
In addition, the DRC was retrained on February 17,2026 regarding the importance of having the DME and pre-screen on the residents file before the admission date of the resident. The DRC was reminded that the initial assessment must be done with in 15 days of admission of a resident. Dates of this documentation will be put on the Office Calendar with Date of completion date checked and documented by the DRC upon admission of the resident.
The Director of Resident Care has been reminded that the support plan, based on the initial assessment, must be completed within 30 days of admission. All dates will be documented on the business calendar in the office by the DRC and checked by the Executive Director upon the admission of a new resident.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented ([redacted] - 06/10/2026)

225a - Assessment 15 Days

31. Requirements

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

Description of Violation

Resident 5 was admitted on [redacted]; however, the resident's assessment was not completed until [redacted]

Plan of Correction ***Accept ([redacted] - 02/27/2026)***

A packet has been made up for new admissions including the pre-screen, med evaluation form, and RASP forms so that all forms will be completed in a timely manner and not overlooked. The packets are now with our move in paperwork. This was done by the Director and DRC. Upon admission the due date for the assessment and support plan will be noted on the office desk calendar
The DRC was retrained on the admission process on February 17, 2026 by the Executive Director. Ongoing the DRC is responsible for documenting the dates when the DME, Pre Screen, Initial assessment and completion of the RASP must occur for all new admissions upon the planned admission date. This will be monitored by the Executive Director and rechecked by the floor supervisor, The dates of completion will be documented on the Calendar and initialed by the DRC and Director upon completion.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented ([redacted] - 06/10/2026)

225c - Additional Assessment

32. Requirements

225c Additional Assessment *(continued)*

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 [redacted] does not include the resident's need for turning and positioning in bed, engaging in social and leisure activities, orientation to time date and person. Resident 3's had a half bed rail on [redacted] bed; the resident's assessment does not list a need for this device.

Resident 5's assessment, dated [redacted], does not include that the resident cannot self-administer medications as documented on resident 5's documentation of medical evaluation dated [redacted]

Plan of Correction ***Accept ([redacted] - 02/27/2026)***

Resident #3 An additional assessment has been done which includes the need for turning and positioning when [redacted] is in bed, engaging in social activities and orientation to time, date and place. This resident's bed rail has been removed.
Resident #5 has an order from the physician stating [redacted] is able to administer [redacted] medications. An addendum has been added and the order is attached.
Ongoing, all sections of personal care needs will be addressed on the assessment form by the Nurse and Floor Supervisor.
All Direct Care staff were trained on January 29,2026. at a staff meeting regarding the violations cited at our recent annual inspection. We discussed at the meeting about the timeframes of the assessment and support plans from the date of a resident's admission and when assessments are required. In addition, we addressed the need for all staff to become familiar with the RASPs and as caregivers doing daily care, they need to report when a resident's needs differ from what the current RASP states.
Our Floor Supervisor will review the RASPs of all residents and report any resident's needs that differ from what the current RASP is showing. to the DRC. The DRC will determine if a new assessment and support plan needs to be done or an addendum and will document the corrections as is appropriate. The reviews will be done monthly unless a significant change occurs sooner. In that case the DRC will immediately address the change as is appropriate.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented ([redacted] - 04/06/2026)

227a Support Plan 30 Days

33. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident 5 was admitted on [redacted]; however, the resident's initial support plan was not completed until [redacted]

Plan of Correction ***Accept ([redacted] - 02/27/2026)***

This resident (#5) was admitted to Legacy Gardens [redacted] At the time the support plan was due the resident's health had declined, and we were unsure of [redacted] outcome. Sent was hospitalized [redacted], and did not return

227a - Support Plan 30 Days (continued)

to us until late [redacted]. By the time we realized the support plan had not been finished it was [redacted] and we should have obtained a new DME but failed to do so. The RASP was completed at this time. This was an isolated situation,
However, ongoing our business calendar will be marked with admission date, prescreen date, initial assessment and support plan by the Director of Resident Care upon admission of a resident. This will be initialed by the DRC as completed and monitored and reviewed by the Executive Director or Floor Supervisor for any deficiencies when the admission records are completed.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented ([redacted] - 06/10/2026)

227g -Support Plan Signatures

34. 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 3 participated in the development of [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

Resident 5 participated in the development of [redacted] support plan on [redacted] However, the resident did not sign the support plan.

Resident 8 participated in the development of [redacted] support plan on [redacted] However, the resident did not sign the support plan.

Plan of Correction ***Accept ([redacted] - 02/27/2026)***

Ongoing, all residents will be given the opportunity to assist with the development of their support plan and will be given the opportunity to sign the plan. Residents #3 and #5 support plans have now been reviewed and their signatures obtained to the current support plan. Resident #8 would not have been able to assist with [redacted] support plan due to [redacted] cognition. However, ongoing we will document this on that signature space when the resident is unable to sign.
If a resident is truly unable to or refuses to participate, this will be noted on the residents document in the appropriate location.
All staff currently responsible for completing the RASPs were retrained February 17, 2026. The content of this training was taken from the Regulatory Compliance Guide, The Preadmission Screen, Medical Evaluation and the Assessment- Support Plan- Best Practices. A monthly audit of all residents' RASPs is being done by the Floor Supervisor and DRC.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented ([redacted] - 04/06/2026)

227h - Support Plan Refuse Sign

35. Requirements

227h - Support Plan Refuse Sign *(continued)*

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident 2 participated in the development of [redacted] support plan on [redacted] The resident was unable to sign the support plan. The home did not make a notation regarding the resident's inability to sign.

Plan of Correction ***Accept ([redacted] - 02/27/2026)***

The Director of Resident Care has created a checklist for the support plan which includes all sections of the support plan and signatures of all who participate in the development of their assessment and support plan. This was done February 18, 2026.

If a resident is truly unable to or refuses to participate, this will be noted on the residents document in the appropriate location.

All staff currently responsible for completing the RASPs were retrained February 17, 2026. The content of this training was taken from the Regulatory Compliance Guide, The Preadmission Screen, Medical Evaluation and the Assessment- Support Plan- Best Practices. A monthly audit of all residents' RASPs is being done by the Floor Supervisor and DRC.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented ([redacted] - 04/06/2026)

251b - Record Entries Legible

36. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Initials on resident 11's 12/2025 Medication Administration Record are not legible.

Plan of Correction ***Accept ([redacted] - 02/27/2026)***

Looking at the initials on the MAR Master Signature sheet we feel that the initials match. However, ongoing med staff will print their initials to make them more legible to others. This training was included in the medication staff training held on January 29,2026 and will be reviewed at the medication training scheduled for March 2026.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented ([redacted] - 04/06/2026)