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

May 1, 2026

[redacted], ED
DRESHER MC OPCO, LLC
[redacted]

RE: VIVA MEMORY CARE AT DRESHER
1424 DRESHERTOWN ROAD
DRESHER, PA, 19025
LICENSE/COC#: 15164

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/05/2026, 01/06/2026 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *VIVA MEMORY CARE AT DRESHER* **License #**: *15164* **License Expiration**: *06/11/2026*

Address: *1424 DRESHERTOWN ROAD, DRESHER, PA 19025*

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

Administrator

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

Legal Entity

Name: *DRESHER MC OPCO, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/19/2019* **Issued By**: *Township of Dublin*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *90* **Waking Staff**: *68*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *01/06/2026*

Inspection Dates and Department Representative

01/05/2026 - On-Site: [redacted]

01/06/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *45*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *66* **Residents Served**: *45*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *45*

Diagnosed with Mental Illness: *15* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *45* **Have Physical Disability**: *4*

Inspections / Reviews

01/05/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/16/2026*

03/03/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/01/2026*

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

Inspections / Reviews *(continued)*

03/06/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/01/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/30/2026*

05/01/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/01/2026*

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] resident #1 was admitted to [redacted] Hospital for [redacted]. The home did not report this incident to the Department.

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

Immediate Action
Incident Report for Resident #1 submitted on 3/2/26.

Quality Improvement
Review of observation notes and internal incidents was completed on 2/24/26 and one incident was identified that needed to be reported. That report was submitted on 2/28/26.
Beginning 3/2/26, a daily audit of all incidents and observations will be completed by the Executive Director and RCD for 8 weeks looking for reportable incidents and reporting them.
This audit will be submitted to the QA committee for tracking and trending of identified process issues and correction with further recommendations made. If no identified issues and complaint for 4 consecutive weeks threshold achieved.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 04/29/2026)

18 Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Personal Care Homes and Assisted Living Residences must post the required influenza information in a public place in the home year-round as required by the Influenza Awareness Act (HB 1785). On 1/5/2026, the home did not have an influenza poster anywhere.

Plan of Correction ***Accept ([redacted] - 03/02/2026)***

Immediate Action
Surveyor emailed flu poster to ED on 1/7/26. Poster was printed and posted in all public bathrooms and at the front desk.

Quality Improvement
ED identified the following areas where the flu poster will be displayed year-round: five (5) public bathrooms, employee breakroom, front desk, nurse/medtech station. Beginning on 1/11/26, Maintenance Director will include the five locations in [redacted] building rounds, once per week, to ensure the poster is still visible and in good condition in those locations. Missing or damaged posters will be replaced immediately by the Maintenance Director. Review of the results of the MD rounds will be held during the weekly ED/MD 1:1 meeting for 2 months.

18 - Compliance With Laws (continued)

Licensee's Proposed Overall Completion Date: *03/06/2026*

Implemented (- 04/29/2026)

23a - Activities of Daily Living Assistance

3. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated , for resident#1 indicates the resident requires assistance with personal hygiene, toileting, bladder management, bowel management, eating, drinking, transfers in and out of bed and chair, turning and positioning. On , it's unknown if the resident received the assistance as required from 6:00 am - 2:00 pm. Staff person A was scheduled to work 6:00 am-2:00 pm and disclosed that if got the resident up for the day, it would have been around 12:00 pm but does not recall and would have asked staff person B for assistance. Staff person B denied providing assistance to the resident on . Staff person C was scheduled to work shift at 2:00 pm - 10:00 pm and disclosed not checking on the resident at the start of the shift. Staff person D stated that at approximately 4:26 pm staff person C asked for assistance with resident #1. Staff person C then learned from an unknown staff person that the resident was transported to the hospital by ambulance.

Plan of Correction ***Accept (- 03/06/2026)***

Immediate Action
On 2/3, 2/4 and 2/5/26 caregivers were trained to resident's rights, and OAPSA Abuse and Neglect reporting, and retrained to the care tracking system available in the EMR. Staff were also retrained to their responsibility to do rounds on all shifts placing eyes on all assigned residents within the first 30 minutes of the shift and at minimum, every 2 hours . Staff on all shifts are reminded several times per shift to use the care tracker to log all care provided to each resident and to round.
Quality Improvement
Beginning the week of 2/2/26, the care tracking percentage will be pulled on the Saturday ending the week to get a baseline for the use of the care tracking system. For 8 weeks following, the care tracking percentage will be pulled on Saturday to show improved use of the tracker, week over week. The goal after 8 weeks will be 95% usage/completion. The week over week tracking and trending will be given to the QAQI committee for review and if tracking needs to continue if the threshold is not reached in 8 weeks.

Licensee's Proposed Overall Completion Date: *03/28/2026*

Implemented (- 04/29/2026)

25b - Contract Signatures

4. Requirements

25b Contract Signatures *(continued)*

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 or the administrator.

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

Immediate Action
The contract for Resident #1 was signed by the administrator/designee and it was noted on the contract that during the contract signing, the POA stated the resident was unable to sign the contract.

Quality Improvement
The BOM audited current contracts for compliance to Resident and Administrator/designee signature. If Resident was able to sign, signature obtained, otherwise, a note was placed on the resident signature line that the resident was unable to sign. Administrator signed only the contracts that were dated from the start of her tenure as the administrator.

Beginning 2/1/26, the BOM will perform a monthly audit of all contracts signed the previous month for compliance of a resident's signature and the Administrator/Designee's signature on the contract. Results of the audit will be brought to the QAQI meeting until 100% compliance is reached for 2 months.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 04/29/2026)

42b Abuse

5. Requirements

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

Description of Violation

Resident #1 was admitted to the home on [redacted] The home documented in the resident's progress note that a skin assessment was completed and noted no concerns. On [redacted] resident #1 had an unwitnessed fall in [redacted] bedroom, the resident was found on the floor on all fours with [redacted] head on the ground. The resident was assessed and no bruising noted however there was redness on their knees and elbow.

Resident #1 was admitted to [redacted] Hospital on [redacted] The Department was notified that resident #1 arrived at the hospital with bruising throughout the body including head, posterior left knee, abdomen, [redacted] The resident's mouth was dry and crusted with dark colored debris and [redacted] left fifth toenail almost fell off. The assessment and support plan, dated [redacted], for resident#1 indicates the resident requires assistance with personal hygiene, toileting, bladder management, bowel management, eating, drinking, transfers in and out of bed and chair, turning and positioning. The assessment and support plan, dated [redacted] indicates the resident requires extensive supervision. On [redacted], its unknown if the resident received any assistance as required from 6:00 am-2:00 pm.

42b - Abuse (continued)

Staff person A was scheduled to work 6:00 am-2:00 pm and [redacted] stated that if [redacted] provided care, it would have been around 12:00 pm but does not recall and would have asked staff person B for assistance. Staff person B denied providing assistance to the resident on [redacted] Staff person C was scheduled to work [redacted] shift at 2:00 pm-10:00 pm and disclosed not checking on the resident at the start of the shift. Staff person D disclosed that around 4:26 pm staff person C asked [redacted] for assistance with providing care to the resident. Staff person C then learned from an unknown staff person that the resident was transported to the hospital via ambulance.

Staff person E disclosed that [redacted] walked past the resident's room and heard concerns with the resident's breathing at approximately 2:00 pm. Staff person E stated that at approximately 3:00 pm the resident was assessed and care was provided and the resident was sent to the hospital via ambulance. The home did not have documentation of the resident having bruises on [redacted] body. Resident #1 was admitted to the hospital on [redacted]

Resident #1's medical documentation from the resident's medical provider dated [redacted] following the resident's hospital stay and return to the home notates the resident was presented to the hospital for change of mental status. Resident was noted to have [redacted].

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

This tag speaks more to the lack of documentation of care or that a care plan was not followed. That lack of recollection and documentation could lead to an assumption that neglect may have happened. However, not recollecting when or what care was given or if care was given does not conclude abuse. In this case there was documentation that care was provided by the ED and RCD at times prior to the resident's transport to the hospital and that there was no bruising observed by the ED and RCD on the resident. When the OAPSA investigated, they appeared accepting of the documentation and interview provided by the home regarding the resident's documented fall as it related to the bruising and did not remove the the resident from the facility. As for a tag of abuse to the home, the resident was not in the home's sole custody as [redacted] was in the custody of the ambulance service and the hospital. Bruises could have been acquired by rough handling by the ambulance company or something that happened during transfer a the hospital. If it cannot be determined where the bruises came from, how can it be determined that it was abuse at the community? It is for that reason, I am addressing this POC as it relates to documentation of care at the community.

Immediate Action
On 2/3, 2/4 and 2/5/26 caregivers were trained to resident's rights, and OAPSA Abuse and Neglect reporting, and retrained to the care tracking system available in the EMR. Staff were also retrained to their responsibility to do rounds on all shifts placing eyes on all assigned residents within the first 30 minutes of the shift and at minimum, every 2 hours . Staff on all shifts are reminded several times per shift to use the care tracker to log all care provided to each resident and to round.

Quality Improvement
Beginning the week ending 1/31/26, the care tracking percentage will be pulled on the Sunday after the end of the week to get a baseline for the use of the care tracking system. For 8 weeks following, the care tracking percentage will be pulled on Sunday for the previous week to show improved use of the tracker, week over week. The goal after 8 weeks will be 90% usage/completion. The week over week tracking and trending will be given to the QAQI

42b Abuse (continued)

committee for review and if tracking needs to continue if the threshold is not reached in 8 weeks.

Licensee's Proposed Overall Completion Date: *03/28/2026*

Implemented ([redacted] - 04/29/2026)

65a - FS Orientation 1st Day

6. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person F, whose first day of work was [redacted], did not receive orientation on the following topics: Fire safety and emergency preparedness until [redacted]

Plan of Correction ***Accept ([redacted] - 03/02/2026)***

On or about 8/1/25, an onboarding process was developed to insure that the requirements of regulation 2600.65.a were documented as completed in the new employee orientation process.

An audit tool was created on or about 12/1/2025 to review employee files for regulatory compliance to 2600.65.a and all employee files were audited. Any employee onboarded before the current BOM was in the position had a form placed in their file indicating when/whether Orientation Day Fire Safety Training was completed. Any employee onboarded after the current BOM was in the position has the form indicating that First Day Orientation Day Fire Safety Training was completed on their first day.
Beginning 2/1, the BOM will audit all employee files hired the previous month for compliance to all regulatory components of the file. Audits will be reviewed in the BOM/ED 1:1 meeting for completion, tracking and trending.

Licensee's Proposed Overall Completion Date: *03/06/2026*

Implemented ([redacted] - 04/29/2026)

65b - Rights/Abuse 40 Hours

7. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.

65b Rights/Abuse 40 Hours *(continued)*

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person F completed [redacted] 40th scheduled work hour on the first week of [redacted]. However, this staff person did not complete training in the following topics until [redacted]

- *Resident rights*
- *Emergency medical plan*
- *Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102)*
- *Reporting of reportable incidents and conditions*

Plan of Correction ***Accept ([redacted] - 03/02/2026)***

On or about 8/1/25, an onboarding process was developed to insure that the requirements of regulation 2600.65.b were documented as completed in the new employee orientation process.

An audit tool was created on or about 12/1/2025 to review employee files for regulatory compliance to 2600.65.b and all employee files were audited. Any employee onboarded before the current BOM was in the position had a form placed in their file indicating when/whether the components of 2600.65.b were completed. Any employee onboarded after the current BOM was in the position has the form indicating the components of 2600.65.b were completed on their first day.
Beginning 2/1, the BOM will audit all employee files hired the previous month for compliance to all regulatory components of the file. Audits will be reviewed in the BOM/ED 1:1 meeting for completion, tracking and trending.

Licensee's Proposed Overall Completion Date: *03/06/2026*

Implemented ([redacted] - 04/29/2026)

65e - 12 Hours Annual Training

8. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person F received 0 hours of annual training in training year 2025.

Direct care staff person G received only 1.5 hours of annual training in training year 2025.

Direct care staff person H received 0 hours of annual training in training year 2025.

65e 12 Hours Annual Training (continued)

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

Immediate Action
In August of 2025, initial 12 hours of training is provided as part of orientation.
January staff training per the 2026 training schedule was posted on 1/9/26 for staff to read and acknowledge with signature. Training will be done with posting material to be read, online assignments and in person training.

Quality Improvement
The BOM was educated on 1/12/26 on to the annual 12 hour training requirement for direct care staff after initial hire and [redacted] responsibility to manage it. BOM will use the 2026 training calendar, and trainings will be logged on the 2026 training sheet. The training sheet will be reviewed by the QAQI committee for progress and compliance, as well as tracking and trending to make adjustments as needed. QAQI committee involvement will continue until 2 months of 100% compliance is achieved.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 04/29/2026)

65f - Training Topics

9. 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 G did not receive the following training during training year 2025:

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

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

Immediate Action

65f Training Topics (continued)

In August of 2025, training topics listed in 2600.65.f are provided as part of orientation. The 2026 annual training calendar was provided to the surveyor and these topics are listed as part of the annual training plan.
January staff training per the 2026 training schedule was posted on 1/9/26 for staff to read and acknowledge with signature. Training will be done with posting material to be read, online assignments and in person training.

Quality Improvement
The BOM was educated on 1/12/26 on to the annual training requirement for direct care staff after initial hire and [redacted] responsibility to manage it. BOM will use the 2026 training calendar, and trainings will be logged on the 2026 training sheet. The training sheet will be reviewed by the QAQI committee for progress and compliance, as well as tracking and trending to make adjustments as needed. QAQI committee involvement will continue until 2 months of 100% compliance is achieved.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 04/29/2026)

65g - Annual Training Content

10. 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 G, did not receive training on the following topics during 2025 training year:
- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *Resident rights.*
- *The Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).*
- *Falls and accident prevention.*
- *New population groups that are being served at the home that were not previously served, if applicable*

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

Immediate Action
In August of 2025, training topics listed in 2600.65.g are provided as part of orientation. The 2025 annual training calendar was provided to the surveyor and these topics are listed as part of the annual training plan.
January staff training per the 2026 training schedule was posted on 1/9/26 for staff to read and acknowledge with signature. Training will be done with posting material to be read, online assignments and in person training.

Quality Improvement
The BOM was educated on 1/12/26 on to the annual training requirement for all staff and volunteers after initial

65g Annual Training Content (continued)

hire and [redacted] responsibility to manage it. BOM will use the 2026 training calendar, and trainings will be logged on the 2026 training sheet. The training sheet will be reviewed by the QAQI committee for progress and compliance, as well as tracking and trending to make adjustments as needed. QAQI committee involvement will continue until 2 months of 100% compliance is achieved.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 04/29/2026)

85a - Sanitary Conditions

11. Requirements

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

Description of Violation

On 1/5/2026, at approximately 9:50 am, resident #2 had dried blood on [redacted] pillow and bed linens.

On 1/5/2026, at approximately 9:58 am, in the laundry storage room there was an open dove bar soap on the storage rack without a container or the resident's name.

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

Immediate Action
Resident #2 pillow and bed linens were changed on 1/5/26.
The unlabeled bar of soap found in the laundry storage room was discarded on 1/5/26.

Quality Improvement
A review of all resident's bedlinens was completed on 1/6/26 to assure they were clean and sanitary. A review of all resident's bar soap was completed to assure all were kept in a container labeled with resident's name.

All care staff were in serviced 1/7/26 through 1/13/26 on proper procedure to obtain containers for bar soap with resident's name and to change bed linens anytime they are soiled.

An audit will be completed weekly for sanitary conditions to include but not limited to bed linens and proper storing of bar soap by the RCD and Lead Caregiver for 8 weeks. Results submitted to QA committee for further recommendations of tracking/trending of findings until 100% compliance achieved for 4 weeks.

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented ([redacted] - 04/29/2026)

95 - Furniture and Equipment

12. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

95 - Furniture and Equipment *(continued)*

Description of Violation

On 1/6/2026, at approximately 3:17 pm, the shared bathroom for residents in room 23A and 23B does not have a toilet paper holder.

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

Immediate Action
Upon notice by the surveyor, the toilet paper holder was replaced in the bathroom on room 23.

Quality Improvement
Housekeeping staff were educated by the Maintenance Director on identifying and reporting broken or missing toilet paper holders as part of their daily routine. Housekeeping staff are to note items on their daily checklist and Maintenance Director will review the housekeeping checklist the following day for the needed repairs. Maintenance Director will track the reporting of toilet paper holders that need to be replaced, daily, Monday - Friday, for 8 weeks beginning 1/19/26 to ensure compliance. The results if the 8-week audit will be reviewed in the monthly QAQI meeting for trends in housekeeping staff's reporting of necessary repairs.

Licensee's Proposed Overall Completion Date: *03/20/2026*

Implemented ([redacted] - 04/29/2026)

101j3 - Bed/Linens/Pillows/Blankets

13. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The bed for resident #2 did not have a pillowcase on [redacted] pillow.

Plan of Correction ***Accept ([redacted] - 03/02/2026)***

Immediate Action
A pillowcase was put onto resident #2's pillow. All resident bed pillows were observed for the presence of a pillowcase and one was put on if needed.

Quality Improvement
Staff were educated 1/7/26 through 1/13/26 to observe resident bedding daily during AM care and PM care, and replace any bedding item that are missing, immediately. Beginning 1/19/26 and for 8 weeks, RCD and/or Lead caregiver will perform 10 random room checks 3 days per week on first and/or second shift ensuring clean and appropriate linens on each bed. Corrections/remediation will be made on the spot with the assigned caregiver, if necessary. Results of audits will be brought to Monthly QAQI meeting for committee review and trending. Audits will continue for 4 additional weeks if 100% compliance is not achieved at the end of 8 weeks.

Licensee's Proposed Overall Completion Date: *03/13/2026*

Implemented ([redacted] - 04/29/2026)

101j7 - Lighting/Operable Lamp

14. Requirements

2600.

101j7 Lighting/Operable Lamp *(continued)*

101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #1 does not have access to a source of light that can be turned on/off at bedside. The bedside lamp was not within reach from the resident's bed.

Resident #2 does have a bedside lamp; however, the light source did not turn on.

Plan of Correction ***Accept ([redacted] - 03/02/2026)***

Immediate Action
Upon notice by the surveyor, a tap light was installed on the wall at the head of Resident #1's bed so it can be reached by resident Also, upon notification by surveyor, the lightbulb was replaced in the lamp next to Resident #2's bed.

Quality Improvement
Housekeeping staff were instructed to check all lights in resident rooms on the day each week that the room is cleaned. Housekeeping staff are to note on the housekeeping checklist if lights are present, within arm's reach, and operable or need to be replaced. Maintenance Director will review the housekeeping checklist the following day for the need to replace devices or bulbs. Maintenance Director will track the reporting of lights fixtures or bulbs that need to be replaced, daily, Monday Friday, for 4 weeks to ensure compliance. The results if the 4 week audit will be reviewed in the next Community QAQI meeting.

Licensee's Proposed Overall Completion Date: *03/05/2026*

Implemented ([redacted] - 04/29/2026)

132c - Fire Drill Records

15. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drills conducted on 1/31/2025, 2/21/2025, 3/5/2025, 4/25/2025, 5/6/2025, 6/12/2025, 7/23/2025, 8/13/2025, 9/28/2025,10/20/2025, 11/15/2025, and 12/18/2025 does not include the number of the residents present in the home at the time of the drill.

132c - Fire Drill Records *(continued)*

Plan of Correction ***Accept ([redacted] - 03/02/2026)***

Immediate Action
Upon notice by the surveyor, that the fire drill log indicated "ALL" residents were evacuated during the drill rather than the actual number of residents, the Maintenance Director rewrote the 2025 fire drill log to be compliant.

Quality Improvement
Maintenance Director revised the fire drill log to indicate that a number is required in all fields that ask the question how many. The form was reviewed by the ED and approved. The form was reviewed by the ED after the January fire drill and the February fire drill. the Maintenance Director completed the form appropriately.

The fire drill log and schedule will be reviewed and discussed at each monthly QAQI meeting held on the first Thursday of each month.

Licensee's Proposed Overall Completion Date: *03/05/2026*

Implemented ([redacted] - 04/29/2026)

132e - Fire Drill Sleeping Hours

16. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 12/18/2025 at 2:30 am. The previous sleeping hours fire drill was conducted on 2/21/2025 at 11:02 pm.

Plan of Correction ***Accept ([redacted] - 03/02/2026)***

Immediate Action
The Maintenance Director immediately created a 2026 fire drill calendar to indicate which shift a fire drill is to be conducted each month, ensuring that the time between fire drills on a shift do not exceed 6 months.

Quality Improvement.
Maintenance Director conducted the January and February fire drills per the schedule and submitted the fire drill log to the ED after the February Drill. ED ensured compliance with regulation 2600.132.e and 2600.132.c.

The fire drill log and schedule will be reviewed and discussed at each monthly QAQI meeting held on the first Thursday of each month.

Licensee's Proposed Overall Completion Date: *03/05/2026*

Implemented ([redacted] - 04/29/2026)

162c - Menus Posted

17. Requirements

2600.

162c Menus Posted *(continued)*

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

Description of Violation

On 1/5/2025, at approximately 10:07 am, the home's menu for the week of 1/5/2026 through 1/18/2026 was not posted. However, the daily menu for 1/3/2026, 1/4/2026 and 1/5/2026 was posted.

Repeated Violation: 2/27/2025

Plan of Correction ***Accept (- 03/02/2026)***

Immediate Action
On Tuesday, 1/6, the FSD posted the 4 week menu for 1/4/26 1/31/26 on the bulletin board in the dining room.

Quality Improvement
Beginning 1/23/26, The FSD or designee is responsible to post the 2 week cycle menu on the bulletin board in the dining room, weekly, on Friday. ED or designee is responsible to audit that the menu is posted for the following 2 weeks by end of business on Fridays. ED to log the audits weekly for 4 weeks and then bi weekly for 8 weeks and report audit findings in QAQI meeting the second Thursday of each month. Next meeting 3/5/26.

Licensee's Proposed Overall Completion Date: *03/05/2026*

Implemented (- 04/29/2026)

171b5 - First Aid Kit

18. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the Ford bus used to transport residents does not include a breathing shield.

Plan of Correction ***Accept (- 03/02/2026)***

Immediate Action
Breathing shield was purchased for and placed into the first aid kit in the community van on 1/30/26. Van was not used in the month of January or February due to weather.

Quality Improvement
Beginning 3/2/26, the Maintenance Director will inspect the contents of the First Aid kit from the bus monthly to ensure the breathing mask is present in the kit. Maintenance Director will report findings in the next QAQI committee meeting.

Licensee's Proposed Overall Completion Date: *03/30/2026*

Implemented (- 04/29/2026)

183d - Prescription Current

19. Requirements

2600.

183d - Prescription Current *(continued)*

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 1/6/2026, at approximately 2:14 pm, APAP 325 mg prescribed for resident #1, was in the home's medication cart number 1; however, the medication was discontinued on 1/2/2026.

Repeated Violation: 4/22/2025, 2/27/2025

Plan of Correction ***Accept (- 03/06/2026)***

Immediate Action
Resident #1 APAP was removed from medication cart #1 on 1/6/26.
A medication cart audit was completed on 1/7/26 of all medication carts to assure no other discontinued medications remained on the medication carts.

Quality Improvement
RCD educated all medication passing staff on 1/12, 1/13 and 1/14/26 to remove all discontinued medications from the cart when orders are received to discontinue.
The weekly medication cart audit was revised on 1/14/26 to include removing all discontinued medications.
Medication cart audits will continue weekly. The day of the audit will be Thursdays and will be monitored by the RCD for the next 10 weeks. Results of weekly audit will be given to the QA committee for tracking and trending of identified issues and QA committee will make further recommendations if needed until 100% compliance achieved for 4 weeks.

Licensee's Proposed Overall Completion Date: *03/26/2026*

Implemented (- 04/29/2026)

183e - Storing Medications

20. 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 1/6/2025, at approximately 1:57 pm, there was one loose pill in medication cart number 1. Staff identified the pill as Gabapentin.

Repeated Violation: 4/22/2025, 2/27/2025

Plan of Correction ***Accept (- 03/06/2026)***

Immediate Action
One loose pill, identified as Gabapentin, in medication cart #1 was removed from the cart and disposed of according to policy on 1/6/26.
A medication cart audit was completed on 1/7/26 of all medication carts to assure no other discontinued medications remained on the medication carts.

Quality Improvement
RCD educated all medication passing staff on 1/12, 1/13 and 1/14/26 to check medication cups and bingo cards

183e - Storing Medications (continued)

for each passed medication that the pill cleared the card and was in the cup.
The weekly medication cart audit was revised on 1/14/26 to include searching the cart for loose medications. Medication cart audits will continue weekly. The day of the audit will be Thursdays and will be monitored by the RCD for the next 10 weeks. Results of weekly audit will be given to the QA committee for tracking and trending of identified issues and QA committee will make further recommendations if needed until 100% compliance achieved for 4 weeks.

Licensee's Proposed Overall Completion Date: *03/26/2026*

Implemented ([redacted] - 04/29/2026)

190a - Completion Medication Course

21. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person I, who has not successfully completed the Department-approved medications administration course, administered medications to resident #3 to include the following:

- *Levothyrine 100 mcg tab on 1/3/2026 and 1/4/2026 at 6:00 am.*
- *Lorazepam 1mg tab on 1/3/2026 and 1/4/2026 at 6:00 am.*

Staff person I, who has not successfully completed the Department-approved medications administration course, administered medications to resident #4 to include the following:

- *Gabapentin 100 mg caps on 1/2/2026 at 10:00 pm.*
- *Gabapentin 100mg caps on 1/3/2026 and 1/4/2026 at 6:00 am.*

Staff person I, who has not successfully completed the Department-approved medications administration course, administered medications to resident #5 to include the following:

- *Gabapentin 100 mg caps on 1/2/2026 at 10:00 pm.*
- *Gabapentin 100 mg caps on 1/3/2026 and 1/4/2026 at 6:00 am.*

Staff person I did not complete their observations or medication reviews for 2025. The home did not have a copy of the staff's initial qualification and summary form and the summary and requalification form for 2025.

Plan of Correction ***Accept ([redacted] - 03/03/2026)***

Immediate Action
Staff Person I was immediately suspended from passing medications on 1/6/26 pending the receipt of the initial qualification and summary form from [redacted]. Form was unable to be located by the staff person as this home was

190a Completion Medication Course (continued)

not the location of the Staff Person's initial training. Staff person was signed up for and required to complete the medication administration training course, under the supervision of the home's medication administration trainer, [redacted] Staff person completed the course and passed the written exam on 1/16/26 and performed the required observations on 1/16/26. Staff Person I was reinstated to the Medication Tech position to pass medications in the home on 1/16/26.

The qualifications for each Med Tech in the home were reviewed on 1/19/26 and two existing Technicians who did not have the proper paperwork proving initial certification and/or recertification were suspended from passing medications and signed up to retake the course and recertify with the RDC.

Quality Improvement
As of 2/17/26, those two Med Techs have been recertified and reinstated to their Med Tech position.

Beginning 2/2/26, applicants for the Med Tech position, upon setting up an interview, are being asked to provide their credentials showing initial completion of the Med Tech course and observations, as well as semi annual observations and recertification. If credentials are not available and the candidate is offered a position, the individual will perform as a caregiver while being recertified by the home's medication administration trainer. After recertification and appropriate orientation to the Med Tech position, the individual will be scheduled as a Med Tech.

Review of all Med tech applicants and their qualifications will be performed by the BOM and RCD prior to an interview and prior to an offer for employment being made.

A tickler file was created to ensure that semi annual observations/recertifications are performed by the RCD trainer in a timely manner to remain compliant to 2600.190.a. Tickler will be reviewed at the QAQI meeting to ensure semi annual reviewed are completed timely.

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

Implemented ([redacted] - 04/29/2026)

225c - Additional Assessment

22. 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 #2's current assessment was completed on [redacted]. However, the resident's previous assessment was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

Immediate Action
Resident #2's assessment is currently up to date with completion date of [redacted]

225c Additional Assessment (continued)

RCD educated on 1/9/26 that resident's will be assessed annually, if the condition of the resident significantly changes prior to the annual assessment or at the request of the department upon case to believe that an update is required.

Quality Improvement
An audit was conducted by the RCD on 1/14/26 of all resident assessments to determine compliance with regulation 2600.225.c. For any assessments not compliant, residents were assessed, updates were made and signatures obtained.

Beginning 2/1/26, an audit will be conducted monthly for 2 months to assure all resident's assessments are completed per regulation. Results will be submitted to QAQI committee for tracking/trending of identified issues and for further recommendations if 100% compliance not reached for two months.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 04/29/2026)

227g -Support Plan Signatures

23. Requirements

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

Description of Violation

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

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

Immediate Action
Resident #1 did participate in [redacted] support plan however was unable to make [redacted] mark to indicate [redacted] participated. A notation of this was made on the RASP by checking the box that the resident was unable to sign.

RCD educated on 1/9/26 that residents participating in their assessments need to sign their assessment or a notation made of their inability and why.

Quality Improvement
An audit was conducted on 1/14/26 by the RCD of all resident assessments to determine compliance with regulation 2600.227g. For any assessments not compliant, either signatures were obtained or the box was checked and notations made that the resident is unable to sign due to decrease in cognitive ability.

Beginning 2/1/26, an audit will be conducted monthly for 2 months to assure all resident's assessments are signed per regulation. Results will be submitted to QAQI committee for tracking/trending of identified issues and for further recommendations if 100% compliance not reached for two months.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 04/29/2026)

231e - No Objection Statement

24. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept ([redacted] - 03/03/2026)***

Immediate Action
The home's No Objection Statement was presented to the Resident #1's designated person and signed.

Quality Improvement
on 1/14/26, the BOM audited current contracts for compliance to No Objection Statement Signatures. It was discovered that a Xeroxing error meant several recent admissions were without the statement. BOM contacted the designated person for each resident and obtained their signature on the statement.

Beginning 2/1/26, the BOM will perform a monthly audit of all contracts signed the previous month for compliance of a signed No Objection Statement within the contract. Results of the audit will be brought to the QAQI meeting until 100% compliance is reached for 2 months.

Licensee's Proposed Overall Completion Date: *03/06/2026*

Implemented ([redacted] - 04/29/2026)

234a Admission Support Plan

25. 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 #6 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was completed on [redacted]

Repeated Violation: 4/22/2025

Plan of Correction ***Accept ([redacted] - 03/03/2026)***

Immediate Action
Resident#6 support plan cannot be corrected to meet a requirement in the past.
RCD was in-serviced on 1/12/26 of the 2600.234.a regulation stating within 72 hours of 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's record.

Quality Improvement
An audit will occur monthly by the RCD of all new admissions into the community to assure a support plan was developed/implemented/documented within 72 hours of admission or 72 hours prior to admission for 3 months. Tracking/Trending results of audit will be given to the QA committee for any further recommendations until 100% compliance achieved for 2 months.

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

234a - Admission Support Plan *(continued)*

Implemented ([redacted] - 04/29/2026)

236 - Staff Training

26. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person G, who works in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2025 training year.

Plan of Correction ***Accept ([redacted] - 03/03/2026)***

Immediate Action
In August of 2025, training topics listed in 2600.236 are provided as part of orientation. The 2026 annual training calendar was provided to the surveyor and these topics are listed as part of the annual training plan.

Quality Improvement
The ED, RDC, and Activity Director, who is also a Certified Dementia Practitioner, developed dementia training sessions for existing direct care staff. Training sessions began the week of 1/19/26 and will be ongoing through the end of the year so all existing caregivers are trained per regulation 2600.236 Trainings will be logged on the 2026 training sheet. The training sheet will be reviewed by the QAQI committee for compliance.

Licensee's Proposed Overall Completion Date: *03/06/2026*

Implemented ([redacted] - 04/29/2026)

251b - Record Entries Legible

27. 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

The fire drills conducted on the following dates were written over and is illegible:

- *On 3/5/2025, the number of residents evacuated*
- *On 4/25/2025 the number of residents evacuated and the number of staff participating*
- *On 10/20/2025 amount of time to evacuate*
- *On 12/18/2025 the number of staff participating*

Repeated Violation: 4/22/2025

Plan of Correction ***Accept ([redacted] - 03/03/2026)***

Immediate Action

251b - Record Entries Legible (continued)

Upon notice by the surveyor, the Maintenance Director was educated to the standard and method of making changes to a record to include striking out the miswritten information with a single line, writing "error" next to it, initialing and dating the error. The Maintenance Director rewrote the 2025 fire drill log to be compliant.

Quality Improvement

For the January and February 2026 fire drills, the Maintenance Director completed the fire drill log and submitted it to the ED for review. the log entries were complete and legible. as audited by the ED.

The fire drill log will be reviewed monthly for 2 months during the 1:1 meeting between the Maintenance Director and ED until 100% accuracy obtained.

Licensee's Proposed Overall Completion Date: *03/05/2026*

Implemented ([redacted] - 04/29/2026)

252 - Record Content

28. 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.
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.

252 - Record Content *(continued)*

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 photograph of the resident that is no more than 2 years old.

Resident #7's record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Accept ([redacted] - 03/06/2026)***

Immediate Action
Resident #2's picture was updated on 1/9/26.
Resident #7's picture was updated on 1/9/26.

Quality Improvement
BOM and Concierge were in-serviced on 1/8/26 to the requirement that resident photographs are to be no more than 2 years old and will be responsible to maintain.
An audit was performed on 1/9/26 by the BOM/Concierge of our electronic health records to verify all resident pictures are up to date and no more than two years old. Pictures that we out of date were updated in 1/10, 1/11 and 1/12/26.
A monthly audit will be performed by the BOM or designee with results submitted to the QA committee for tracking/trending of findings with further recommendations if 100% compliance not achieved for two consecutive months.

Licensee's Proposed Overall Completion Date: *03/06/2026*

Implemented ([redacted] - 04/29/2026)