pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **EVADNEY SCOGGINS**
LEGAL ENTITY

To operate **SCOGGINS PERSONAL CARE BOARDING HOME**
NAME OF FACILITY OR AGENCY

Located at **1245 WEST TIOGA STREET, PHILADELPHIA PA 19140**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **26**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **August 12, 2026** until **February 12, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **140151**

ISSUING OFFICER

Juliet Marsala
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/.23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 12, 2026

[redacted]
Administrator
Evadney Scoggins
[redacted]

RE: Scoggins Personal Care Boarding Home
1245 West Tioga Street
Philadelphia, Pennsylvania 19140
License #: 140151

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection January 14 and 21, 2026 and May 7, 2026 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 140150 dated October 11, 2025 to October 11, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from AUGUST 12, 2026 to FEBRUARY 12, 2027.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

[redacted] Marcia Waite Sokale

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
101j3	III	12	$3	$36	15 calendar days from mailing date of this letter
125a	II	12	$5	$60	5 calendar days from mailing date of this letter
183b	II	12	$5	$60	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected and full compliance with the regulation has been achieved by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Lestia Fetzer, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675

[redacted]

Harrisburg, PA 17105-2675
PH: [redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *SCOGGINS PERSONAL CARE BOARDING HOME* **License #**: *14015* **License Expiration**: *10/11/2026*

Address: *1245 WEST TIOGA STREET, PHILADELPHIA, PA 19140*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *EVADNEY SCOGGINS*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *03/14/2024* **Issued By**: *City of Philadelphia*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *15* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *01/21/2026*

Inspection Dates and Department Representative

01/14/2026 On Site: [redacted]

01/21/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served**: *15*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *13*

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

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

Inspections / Reviews

01/14/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *02/19/2026*

03/03/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/25/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/08/2026*

07/21/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/15/2026*

Reviewer: [redacted] **Follow Up Type:** *Bypass Document Submission*

07/22/2026 Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *07/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Enforcement*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On [redacted] the home's current violation report, dated [redacted] was posted in a locked glass cabinet and is inaccessible to residents.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

A copy of the past inspection from 03/11/2025 was posted in the lounge and dining/living room areas on 1/21/2026. An additional report was posted by staff person A in the back hallway area on 2/25/2026 (see proof). On 3/10/2026, the placement of the POC was added to the checklist for our facility walkthrough to ensure compliance. The administrators will check daily starting on 3/10/2026. If, at any time, the posted reports are missing, the administrator will replace them immediately and document the outcome in the daily log book. The responsible individual to make sure compliance is continued will be the administrator's proposed completion date, 3/10/2026 (see pictures)

Licensee's Proposed Overall Completion Date: *03/15/2026*

Not Implemented [redacted] - 07/21/2026)

5a1 DHS Access

2. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On [redacted] at 10:00 AM, an agent of the Department requested access to resident bank records, which are managed by the home. Staff person A did not provide access to this information.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Starting on 3/31/2026 and going forward, copies of the bank record for each resident for whom the home does financial report management will be replaced for older residents. This will be done in conjunction with the monthly deposit withdrawal records, which are currently being signed and kept in the resident's folders, along with the quarterly financial records, which also indicate the funds coming into the resident's home (see proof), each signed by the recipient showing the amount received. The administrators will ensure the bank statements will be in folders starting on March 31, 2026

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

Implemented [redacted] - 07/21/2026)

17 Record Confidentiality

3. Requirements

2600.

17 - Record Confidentiality *(continued)*

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 [redacted] at 9:31 AM, resident records and medical information were unlocked, unattended, and accessible in the unlocked office in a large unorganized pile.

Plan of Correction ***Accept [redacted] 03/18/2026)***

The administrator did not complete cleaning the office; therefore, unfortunately, resident/staff folders were not securely locked away at the time of the inspection. During the week of 1/21/2026, the office was finally cleaned up, and all resident folders and staff records were again safely locked away in the file cabinet. Keys for the cabinet are kept with staff A. The administrators will do a weekly walk-through of the facility to ensure compliance. Beginning in March 2026 and every quarter thereafter, the home will receive training in accordance with 2600 regulations and training specific to the home. Administrators are responsible for continued compliance. Resident and staff files will be audited quarterly by administrators and designees.

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

Not Implemented ([redacted] - 07/21/2026)

26a - Quality Management Plan

4. Requirements

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

Description of Violation

The home has not implemented it's quality management plan as it could not provide documentation of the last time a quality management meeting had been held and what was discussed at that meeting.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

A quality management plan was created in 2006. The home keeps all policies and procedures in an oversized binder. Unfortunately, the on-duty administrator did not provide the policy to the inspector. [see attached] policy and updates, and how to do reviews and document information. In the future, to ensure compliance, the home will do monthly monitoring starting April 1, 2026. Documentation of such monitoring and meetings with residents and staff will be kept in a new binder called quality management notes. The format of the meeting is attached (see proof), as is how to hold these meetings. The new binder will be kept in a locked cabinet in the office and will be available for review by the appropriate entities. The administrator® will be responsible for maintaining the binder, and a log will be kept showing audit dates and when each audit was completed. The administrator and direct care staff will receive education on the documentation required for quality management and on how to address issues or concerns appropriately. The administrator is responsible for compliance. expected to be finalized on 4/30/2026.

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

Not Implemented [redacted] - 07/21/2026)

51 - Criminal Background Check

5. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person B who was hired on [redacted] had a background check that was completed on [redacted], over 1 year prior to the date of hire.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

The violation in this area occurred because the administration failed to follow the established home protocol (see attached checklist). The checklist states that a criminal background check must be completed upon hire and be done prior to the new hire being allowed to work in the home. [see list]. To remedy the situation, the staff will be removed from the active roster until an e-patch application is completed [proposed completion date 3/31/2026]. To prevent this error in the future, the administrator will follow our established checklist when hiring prospective staff and will complete the hiring process only after all required documents have been received. 2 All current staff folders will be audited every quarter by March, June, September, and December of each year. Audit documentation will be kept in the locked cabinet in the office. Administrators will be responsible for each audit, remedy any deficiencies, and keep the audit results in a locked cabinet in the office. Training will also occur in these quarters: March, June, September, and December. The source of the training will also be kept, and the dates of these trainings will be given. This process will be ongoing every year. Initial training will be in March 2026.

Licensee's Proposed Overall Completion Date: *04/10/2026*

Not Implemented [redacted] - 07/21/2026)

62 - Contact List

6. Requirements

2600.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person A, does not maintain a list of staff persons. On [redacted] the staff list was created onsite, and did not include all staff persons who work in the home. It also contained no contact information.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

The office was reorganized the week of 1/21/2026 by staff A. The policy and procedure manual established our staff contact list in 2021. See the picture for this; it shows how sensitive material will be handled and addressed. Every quarter, such as March, June, September, and December, the administrator will audit the staff folders. The information from each audit will be kept in the administrator's file in a locked cabinet in the office (see attached checklist for conducting audits). Each time an audit is conducted, it will show the signature and title of the person who conducted the audit, along with the time it took to complete.

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

Implemented [redacted] - 07/21/2026)

64f - Record of Training

7. Requirements

2600.

64f - Record of Training *(continued)*

64.f. A record of training including the individual trained, date, source, content, length of each course and copies of certificates received shall be kept.

Description of Violation

The home's record of administrator training for staff person A does not include source, and content of all trainings provided.

Plan of Correction ***Accept ([redacted] - 03/18/2026)***

The office was reorganized and cleaned by the week following January 21, 2026. All resident and staff files/records were placed in a lock cabinet in the office. Moving forward, all staff will be scheduled for training in each quarter of the year, starting in March 2026, June, September, and December. The administrator will also audit staff folders every quarter and advise staff when additional credits are needed to comply with 2600 regulations and the job's requirements. After each audit, the forms/documents will be placed in each staff folder, and dates, topics covered, and the source of training will be documented. Moving forward, the administrator will be responsible for planning each staff training at least 1 month before the end of the current and future training year. A copy of the proposed training will be placed in each staff folder, and the administrator will place copies amongst the administrator records in the locked file cabinet.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Not Implemented [redacted] - 07/21/2026)

65f - Training Topics

8. 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 C did not receive training in 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, personal care service needs of the resident, safe management techniques during training year [redacted].

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Due to the deficiency in training for staff member C, all staff file audits will be done by the end of each quarter, starting March 2026, and each quarter thereafter. Due to current staff education deficiencies, all staff will receive monthly training until June 2026. Any deficiency will be documented, and staff training/education will be provided to correct it. Documentation of training, time, and source will then be placed in each staff folder. All training will begin before the end of March 2026. The administrator is responsible for ensuring continued compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

65f - Training Topics *(continued)*

Not Implemented [redacted] - 07/21/2026)

65g - Annual Training Content

9. 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 C did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, and the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) during training year [redacted] to [redacted].

Staff person D did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, and the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) during training year [redacted] to [redacted]

Plan of Correction ***Accept ([redacted] - 03/18/2026)***

Due to the deficiency in training for staff member C, all staff file audits will be done by the end of each quarter, starting March 2026, and each quarter thereafter. Due to current staff education deficiencies, all staff will receive monthly training until June 2026. Any deficiency will be documented, and staff training/education will be provided to correct it. Documentation of training, time, and source will then be placed in each staff folder. All training will begin before the end of March 2026. The administrator is responsible for ensuring continued compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Not Implemented [redacted] - 07/21/2026)

65i - Training Record

10. Requirements

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

Description of Violation

The home's records for direct care staff trainings do not include the source of each training.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Due to the deficiency in training for staff member C, all staff file audits will be done by the end of each quarter, starting March 2026, and each quarter thereafter. Due to current staff education deficiencies, all staff will receive monthly training until June 2026. Any deficiency will be documented, and staff training/education will be provided to correct it. Documentation of training, time, and source will then be placed in each staff folder. All training will

65i - Training Record (continued)

begin before the end of March 2026. The administrator is responsible for ensuring continued compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Not Implemented [redacted] - 07/21/2026)

66a - Staff Training Plan

11. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for the [redacted] training year.

Plan of Correction ***Directed [redacted] - 03/18/2026)***

The office reorganization was completed on January 21, 2026. To prevent a recurrence of this violation, each staff folder will be audited quarterly beginning in March 2026. To address training, each staff member will receive monthly training from March through June 2026 and quarterly thereafter. Documentation of training and hours, source, and all necessary papers will be added to the individual's folder, with copies also added to the administrator's folder. A copy of the 2600 staff required training will also be attached for each staff member to review, ensuring that all required training is covered. Also, to prevent a recurrence of this type of violation, the administrator will ensure that, for each quarter, staff receive some form of training, ensuring the training is always on schedule. The administrator is responsible for complete compliance with the regulations.

Proposed Overall Completion Date: 04/15/2026

***Directed Plan of Correction**: In addition to the above plan, the administrator or designee shall create a written training plan for the homes annual training year, ensuring that all required training topics are listed on the training plan. The Administrator shall create this plan annually PRIOR To the end of the current training year.*

Directed Completion Date: *04/15/2026*

Not Implemented [redacted] - 07/21/2026)

82b - Poisonous Material Storage

12. Requirements

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

Description of Violation

On [redacted] Radiant glass cleaner with manufacturer's label indicating "if ingested call poison control", was stored on an open shelf in the kitchen next to pots and pans.

A container of Sani-cloth Plus disinfecting wipes and a cannister of Pledge wood cleaner both with manufacturer's label indicating "if ingested call poison control", were stored on an open shelf in the kitchen next to a box of Boost supplement drinks.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

This violation occurred because of inappropriate training and improper oversight of the staff by supervisors/ administrators and direct care staff. To prevent this violation from occurring or recurring, staff training will begin in

82b - Poisonous Material Storage (continued)

March 2026 and cover poisonous materials storage and other specific topics as discussed in 2600. and all other topics related to staff training within the personal care home. Further oversight will be provided, and the administrator will conduct a daily walkthrough of the facility to ensure that no chemicals are improperly left hanging. For now, there will be monthly staff trainings until June 2026. We will then use quarterly training. Any issues noticed will be documented and discussed to prevent violations and to educate staff on the necessity of protecting not only staff but especially residents within the home from exposure to poisonous chemicals. For complete compliance within the facility, the administrator is responsible for ensuring proper storage of all chemicals and other hazardous materials. Once training is complete, the audit results from staff and resident folder audits will be placed in the appropriate files in the locked cabinets.

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

Not Implemented [redacted] - 07/21/2026)

85a - Sanitary Conditions

13. Requirements

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

Description of Violation

On [redacted] at 10:32 AM, there was no method to dry hands in the 1st floor bathroom on the [redacted] side. The electric hand dryer was not properly working.

Plan of Correction ***Directed [redacted] - 03/18/2026)***

The administrator ordered hand dryers for the bathroom (see proof.) We are currently awaiting said dryer, which should be delivered by 3/17/2026. Once the dryer is received, installation will be done to correct the violation. Additional hand dryers were ordered to be stored until needed. If one is broken, a replacement will already be on standby. Weekly walk-through will be done by administrators to ensure compliance and to fix any issues as soon as they" pop up".Quarterly audits of the home will help prevent this issue. Audits will be conducted again in March, June, September, and December. The results of each audit will be kept in the administrator's folder, locked in a cabinet in the office. The administrator is responsible for continued compliance.

Proposed Overall Completion Date: 03/20/2026

***Directed Plan of Correction**: In addition to the above plan of correction, and within 7 calendar days of the receipt of this POC, the administrator or designee shall ensure that the all light fixtures in the home are clean and free of debris/insects and any broken or dirty fixtures are replaced or cleaned appropriately. Additionally, light fixtures, hand dryers and all other areas of the home shall be audited during the administrators daily walk through to ensure that all sanitation issues are identified and corrected upon discovery.*

Directed Completion Date: *03/20/2026*

Not Implemented [redacted] 07/21/2026)

85b - Infestation

14. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On [redacted] at 10:25 AM in room 7 on the far bed, there were multiple dead bed bugs on the mattress. The edges of the mattress had signs of bed bug excrement, and all the pillows and sheets reviewed in the home showed additional signs of a bed bug infestation.

Plan of Correction ***Accept ([redacted] 03/18/2026)***

The home is currently using an extermination service to control any infestation monthly. The home also utilizes other exterminators for bed bugs or other pests on a bi-monthly basis. The home staff, along with the administrator, use Crossfire and other bed bug chemicals every week to treat and kill any eggs that have hatched since the exterminator or another source last treated. We're now using vacuuming to clean the beds, baseboards, and other areas of the rooms in the home to prevent any creatures from hatching and becoming a nuisance. Affected materials or property will be disposed of throughout the house by the end of April 2026. Continuous treatment of every room will be done daily, more intensively weekly, and quarterly to eradicate pests within the facility. Documentation of said treatment will be kept in the administrator's office. The person providing the care will also be indicated in this documentation. The type of um chemical or supplies used in this infestation treatment will also be kept by the administrator and securely locked in the file cabinet. Quarterly staff training and education will also be done to help keep the home pest-free. The administrator will also document this education or training and place it in staff folders.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Not Implemented [redacted] - 07/21/2026)

85d - Trash Receptacles

15. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [redacted] at 9:28 AM there was a half full, uncovered, unattended trash can in the kitchen. It contained food debris, papers, soda cans, disposable gloves and cigarette packaging.

Plan of Correction ***Directed [redacted] 03/18/2026)***

The administrator ordered hand dryers for the bathroom (see proof.) We are currently awaiting said dryer, which should be delivered by 3/17/2026. Once the dryer is received, installation will be done to correct the violation. Additional hand dryers were ordered to be stored until needed. If one is broken, a replacement will already be on standby. Weekly walk-through will be done by administrators to ensure compliance and to fix any issues as soon as they" pop up".Quarterly audits of the home will help prevent this issue. Audits will be conducted again in March, June, September, and December. The results of each audit will be kept in the administrator's folder, locked in a cabinet in the office. The administrator is responsible for continued compliance.

Proposed Overall Completion Date: 03/20/2026

Directed Plan of Correction: *In addition to the above plan of correction, and within 7 calendar days of the receipt of this POC, the administrator or designee shall ensure that the all light fixtures in the home are clean and free of debris/insects and any broken or dirty fixtures are replaced or cleaned appropriately. Additionally, light fixtures, hand dryers and all other areas of the home shall be audited during the administrators daily walk through to ensure that all sanitation issues are identified and corrected upon discovery.*

85d - Trash Receptacles *(continued)*

Directed Completion Date: *03/15/2026*

Implemented [redacted] - 07/21/2026)

85e - Trash Outside Home

16. Requirements

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

Description of Violation

On [redacted] at 9:33 AM there were 2 large black trash bags piled on the recycling bin in the back, the trash can next to it was filled with garbage and was unable to close. There was a small single use grocery bag hanging from the fence, and old shoes, a plastic container, and an air conditioner strewn along the side of the [redacted] building.

Plan of Correction ***Directed [redacted] - 03/18/2026)***

After the inspection, the staff, along with the administrator, cleaned the backyard. An additional trash can was placed in the backyard. The private trash removal company was called to remove the excess trash from the backyard. More buckets for the disposal of cigarette butts were added to the backyard (see pictures) to prevent the cigarette butts from ending up on the ground. Training for staff to ensure that sanitary conditions are kept will be completed by the end of March 2026. For now, trainings will be monthly until June 2026. Other trainings will be quarterly. Training will continue every quarter, that is, March, June, September, and December going forward. Documentation of said training will be kept in the locked cabinet in the administrative file in the office. For any issue within the facility, compliance and prevention of recurrent violations will be the responsibility of the administrators.

Proposed Overall Completion Date: 03/15/2026

Directed Plan of Correction: *In addition to the above POC and within 7 calendar days of the receipt of this POC, the administrator or designee shall audit all trash cans and exterior areas of the home, at least weekly to ensure ongoing compliance. Any areas of non-compliance shall be corrected immediately upon discovery.*

Directed Completion Date: *03/15/2026*

Not Implemented [redacted] - 07/21/2026)

87 - Lighting

17. Requirements

2600.
87. Lighting - The home's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On [redacted] the light in the second-floor hall between the [redacted] and [redacted] buildings was inoperable. On the 3rd floor there was no light between the [redacted] and [redacted] buildings. In the front area of [redacted] side the light was so dim a flashlight was needed to be used to read the fire panel.

87 - Lighting *(continued)*

Plan of Correction ***Accept (- 03/18/2026)***

One light was replaced on 1/14/20 26. A weekly walkthrough of the facility will ensure this issue does not recur. Staff training will start on March 2026. All staff will be trained monthly until June 2026, and quarterly thereafter, that is, March, June, September, and December each year. Topics covered will include inspection violations and any deficiencies in the staff training. Documentation will be placed in each staff folder. In addition to weekly monitoring, a daily walkthrough of the facility will be conducted, and any issues will be addressed; documentation will be maintained to ensure that all areas have adequate lighting. Again, the administrator is responsible for complete compliance with 2600. It will be done quarterly to ensure compliance across all areas of the facility.

Licensee's Proposed Overall Completion Date: *03/15/2026*

Not Implemented - 07/21/2026)

88a - Surfaces

18. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On duct tape was holding a privacy panel in place on the front window of side.

On , there was a crack in the window near the kitchen stove. Clear tape was holding the piece of the broken window in place.

On , In the second-floor bathroom, there was water damage on the ceiling. In the corner of the shower, multiple tiles were broken off and missing. The caulk around the shower tub was dried and cracking.

Plan of Correction ***Accept (- 03/18/2026)***

Windows were fixed 3/13/2026(see before and after pictures). Ceiling tiles were replaced in February 2026. Tub and caulking were repaired in February 2026(see pictures). The hand dryer should be replaced on 3/17/2026 (see prior answer). All other dryers were checked on March 11, of March 2026, by the administrator and Sand L workers. Administrators will do a weekly walkthrough of the home. Any infractions will be documented in our daily log and will be fixed. Starting in March 2026, all areas of the home will be audited, and the documentation will be kept. Starting in March and every month until June 2026, all staff will receive training, and documentation will be placed in the folders in the locked cabinet in the office. Audits will be done in March, June, and September. The administrator is responsible for ensuring continued compliance in the home. and December each year. Proper documentation and outcomes will be securely locked away in the file.

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

Not Implemented - 07/21/2026)

89b - Hot Water Temperature

19. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On at 10:15 AM, the hot water temperature in the 3rd floor side bathroom measured 132

89b Hot Water Temperature (continued)

degrees Fahrenheit. On [redacted] at 7:10 AM the water was 130 degrees Fahrenheit.

On [redacted] At 10:22 AM, the hot water temperature in the second floor [redacted] side bathroom measured 145 degrees Fahrenheit.

On [redacted] At 10:32 AM, the hot water temperature in the 1st floor [redacted] side bathroom measured 167 degrees Fahrenheit and at 4:13 PM it was 150.4 degrees Fahrenheit. On [redacted] at 8:06 AM the water was 132.2 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Immediately the water temperature will be lowered to 120 degrees or below, but not lower than 110 degrees Fahrenheit. In the future, the administrator and maintenance staff will be checking the water temperature every 2 days to ensure that that the water temperature is holding at 120 degrees, but no lower than 110 degrees Fahrenheit. All staff will receive training by 03/31/2026 to ensure that they understand the importance of maintaining the proper water temperature at all faucets in the home to protect the health and safety of all residents by preventing burns. The training will be scheduled by the administrator and documentation will be kept in a folder. Proof will be provided.
The temperature log was started on 02/18/2026. Please see the attached picture of the chart.

Proposed Overall Completion Date: 03/31/2026

Licensee's Proposed Overall Completion Date: *03/31/2026*

Implemented [redacted] - 07/22/2026)

95 - Furniture and Equipment

20. Requirements

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

Description of Violation

On [redacted] there were two broken plastic chairs, and multiple broken benches in the smoking area.

On [redacted], In the 3rd floor bathroom on the [redacted] side the shower curtain was torn in a jagged step shape from the bottom. The sink of the bathroom was also completely clogged and not draining.

The dresser in room [redacted] had handles that were only secured on one side and hanging down improperly on each drawer. Some of the handles were also missing.

The door handle for room [redacted] is not secured to the door and is falling off. There is a large gap between the handle and door.

In the 1st floor bathroom on the [redacted] side, the metal heater cover is jagged and protruding from the wall.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

furniture and equipment, including the broken plastic chairs and the broken wooden park benches, were removed from the smoking area (see pictures). New metal benches replaced the old. Drawer handle rm# [redacted] was fixed

95 - Furniture and Equipment (continued)

2/17/2026 (see picture). The drawer handles were fixed in room #10 on 2/17/2026. 2/17/2026.. Radiator covers with jagged edges were temporarily fixed on 2/17/20026 but replaced in full on 3/13/2026 after the administrator bought the proper sheet metal at Home Depot and attached it. (see proof) Additional sheets were bought to have extra on hand to fix any damaged covers in the future (see receipt and pictures). Door handle for Rm [redacted] was fixed 2/17/2026(see pictures)

The torn shower curtain was replaced on 1/15/2026. (see pictures). The clogged sink in the bathroom was cleared by staff during the inspection. The administrator began the inspection and oversight of the facility to address the violations. However, we anticipate that the formal education and training of all staff will begin in March 2026 and continue each month through June 2026. Subsequently, every quarter, that is, March, June, September, and December, more formal education and training will be done. Documentation from this training will be kept in the staff and administrator folders in the office's locked cabinet. The training topics will also be on these forms, as will the time the training took place. Daily, the administrator will conduct a general walk-through of the facility, document any deficiencies, and, along with the housekeeping or maintenance staff, address those problems immediately. Documentation and proof of the training will be provided after the training ends and stored in the folders in the lock cabinet.

Licensee's Proposed Overall Completion Date: *03/31/2026*

Not Implemented [redacted] - 07/21/2026)

100a - Exterior - Free of Hazards

21. Requirements

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

Description of Violation

On [redacted] in the backyard area behind the home there is an uneven brick patio and cracked and uneven cement both which could cause a tripping hazard. Residents use this area for smoking and it is an emergency egress path.

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

We will monitor residents while they are in the yard to ensure that they are not injured while smoking. A contractor was consulted and weather permitting, work should be completed by 4/15/2026. Documentation will be provided upon completion. Administrator or designee will be responsible for ensuring proper completion and maintenance of the area and documentation will be kept for compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented [redacted] - 07/22/2026)

100b - Removal Snow/Obstructions

22. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On [redacted] at 7:00 AM, there was an approximate 1/2 inch accumulation of ice on the back smoking area ground, which is also an exit route. In Philadelphia it last snowed approximately 3 inches on [redacted].

100b - Removal Snow/Obstructions *(continued)*

Plan of Correction ***Accept - 03/18/2026)***

Immediate action: the ice was removed and salt was applied to the area. In the future when there is inclement weather of snow and/or icy conditions the home will immediately salt in both the front and backyard area of the facility. Once the snow has stopped, a staff member will shovel the snow and salt the area to prevent a buildup of ice and snow around the facility. Additionally, staff will salt daily as needed to prevent refreeze and ice buildup. Administrator and designee will be responsible with follow-up during the winter months.
Starting March 2026, staff will receive training/education on the importance of keeping the facility free of any hazard, whether natural (e.g., snow, rain) or manufactured. (see fixed backyard smoking area) Staff education will start in March 2026, and documentation will be kept in the staff and administrative file, locked in a cabinet in the office. Daily, the administrator, housekeeping, and maintenance staff will monitor to ensure the facility is hazard-free. To ensure that this type of violation does not occur again. Staff formal education will be held monthly until June 2026. Afterwards, audits and training classes will be done every quarter. The administrator is responsible for oversight and adherence to all 2600 regulations, and for keeping all audit records safely in locked storage.

Proposed Overall Completion Date: 03/15/2026

Licensee's Proposed Overall Completion Date: *03/15/2026*

Implemented - 07/21/2026)

101j3 - Bed/Linens/Pillows/Blankets

23. 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

On the beds for residents and had sheets were stained and torn with dark red and brown marks which appeared to be blood.

On Resident did not have a pillow. Resident and pillows and pillowcases were covered in dark red and brown marks which appeared to be blood.

Repeat violation:

Plan of Correction ***Accept - 03/18/2026)***

Bed linen, pillows, and blankets. The missing pillow was replaced for resident number one on 1/14/2026 by the staff. They stained the pillows and bed linen for residents 2 and 3, which were removed on 1/14/26, and the staff immediately replaced the clean linen on these beds. To ensure that this violation does not require the administrator and designee, we'll be conducting a daily walkthrough of the facility to ensure that all beds have the proper linens, including pillowcases, pillows, fitted sheets, flat sheets, blankets, or even a spread as needed. If any of the required items are missing, the administrator or designee will immediately have them replaced. If any linens are soiled, they will be replaced immediately, and clean linens will be placed on the beds. The oversight will happen daily by an administrator. This informal training started after the inspection left. Formal education will begin in March 2026, and documentation uncovered during the sessions will be kept in each staff member's folder, along with the administrator's folder. All formal training will be held every quarter: March, June, September, and December. Moving forward, this will prevent the recurrence of this type of violation. The administrator is responsible for general

101j3 - Bed/Linens/Pillows/Blankets (continued)

oversight and adherence to 2600 rules and regulations.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Not Implemented [redacted] 07/21/2026)

101o - Walls, Floors, Ceilings

24. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On [redacted] the floor tiles in bedroom 10 were pulled off the floor and loosely scattered in a pile in the corner. The outlet near the door is coming off the wall about 1/4 of an inch.

The ceiling tiles directly above resident [redacted]s bed were bulging or bowed down, showing a large sign of water damage.

Plan of Correction ***Directed [redacted] 03/18/2026)***

The ceiling above the bed above the bed for resident [redacted] was fixed on 1/17/2026 by the house staff. [See pictures]. Currently, we are working with our construction company to renovate both sides of the building; therefore, specific in-service training and education will begin in March 2026. Documentation and training information will be kept in the staff folders and in the administrator's file to prevent a recurrence. Weekly, and sometimes daily, the administrator and designee will conduct a walkthrough of the facility to ensure there are no hazardous situations for residents. By doing the daily walkthrough, the administrator will hopefully prevent any future violations by addressing issues promptly. [See pictures] Starting March 2026 and every quarter, the expected completion dates for all walk-throughs and monitoring should be April 15, 2026.

Proposed Overall Completion Date: 04/30/2026

***Directed Plan of Correction**: Within 48 hours of receiving this plan of correction, the administrator or designee shall ensure that all loose floor tiles are removed from the area to prevent tripping hazards. The floor shall be inspected to ensure that there are no other hazards to residents until the tiles can be fully replaced.*

Directed Completion Date: *04/01/2026*

Implemented [redacted] - 07/22/2026)

102i - Soap Dispenser

25. 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 [redacted] there was no soap in any bathroom on the 2nd and 3rd floors of the home.

Plan of Correction ***Accept ([redacted] - 03/18/2026)***

The soap dispenser was replaced with soap on January 14, 2026, after the inspection. To prevent any recurrence of this type, an administrator or designee will conduct a daily walk-through to check the bathrooms and other areas of the facility for noncompliance, and any deficiency will be addressed immediately by the administrator or designee.

102i Soap Dispenser (continued)

Documentation will be made in our daily log. A daily checklist for the bathroom and other areas of the facility is currently being developed, and copies will be provided to staff at a future training. Beginning in March 2026 and every month thereafter until June 2026, staff will be offered training. Copies of the training will be placed in staff folders and also in the administrator's files. All will be locked away in the office cabinet. The administrators will begin auditing staff and residents in March 2026 and each quarter thereafter. Copies of each audit will be kept and securely locked away. The administrator is responsible for the overall compliance of 2600.

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

Not Implemented [redacted] - 07/21/2026)

103f - Refrigerator/Freezer Temps

26. Requirements

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

Description of Violation

On [redacted] at 9:21 AM the temperature in the freezer was 10 degrees Fahrenheit. The freezer had not been opened that morning.

Plan of Correction ***Accept ([redacted] 03/18/2026)***

The thermometer was replaced in the freezer because it was defective. Moving forward, staff will do weekly checks to ensure compliance, either by the administrator or other staff. Daily checks are also being made in the areas where issues have arisen. In March of this year, 2026, formal education and training will begin for all staff. Training will continue monthly through June 2026. Thus, each staff member will understand the need for oversight and their responsibility going forward. Documentation of the training will be kept in the staff folders and in the administrative file, both in a lock cabinet in their office. Overall, the administrator is responsible for all compliance under 2600. Audits of resident and staff folders will be conducted quarterly, and the results will be kept secure. Administrators are responsible for continued compliance.

Licensee's Proposed Overall Completion Date: *04/15/2026*

Implemented [redacted] - 07/21/2026)

103i - Outdated Food

27. Requirements

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

Description of Violation

On [redacted], There were 2 undated, white, food containers, containing dried cereals in the basement.

Repeat violation: [redacted]

Plan of Correction ***Directed [redacted] - 03/18/2026)***

Our new policy is 1. dry cereal, cornmeal, potato, mashed, or any items will no longer be removed from their original containers, but will be placed in plastic tubs or bins in their original form. container; this will ensure that their pests are free of moisture and in proper condition for use throughout the facility. Additional items will be placed in barrels; therefore, this type of violation will no longer occur. Immediately after the inspection, this new rule was put in

103i Outdated Food (continued)

place. Weekly checks are being conducted to ensure these items are now handled differently. Starting March 2026 and each subsequent quarter thereafter, staff will be educated and how to deal with um food items especially dried products like cereal rice and etcetera in the facility and that the those items will remain in the container in which they were purchased and locked into the plastic tubs or buckets on the shelves with the additional items being placed in the barrels until use. New training will begin in March 2026 and each month until June 2026. Documentation of these trainings will be kept in the staff folder and also in the administrative files in the locked cabinet in the office. Quarterly training will begin in March and continue each quarter thereafter. The administrator would be responsible for ensuring that the training is completed and that all documentation is properly stored. Admin. Is responsible for facility compliance.

Proposed Overall Completion Date: 03/31/2026

Directed plan of correction: *The home shall provide education to staff on dating and labeling any food items that are opened and how to properly store opened food items in containers that are labeled appropriately by the end of March 2026. The administrator or designee shall audit all food storage areas twice per week in the home to ensure that food items are stored, labeled and dated appropriately. Audits shall continue twice weekly for 1 month, then weekly for 2 months then monthly thereafter. Documentation of the training and completed audits shall be kept and made available to the Department upon request.*

Directed Completion Date: *03/31/2026*

Not Implemented [redacted] - 07/21/2026)

105e - Clean Linen Storage

28. Requirements

2600.
105.e. Clean linens and towels shall be stored in an area separate from soiled linen and clothing.

Description of Violation

On [redacted] linens used by residents of the home were stored directly on the basement floor behind the washer.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Starting January 15, 2026, daily checks will be conducted to ensure that dirty/soiled items are never on the floor. Dirty laundry will not be on the floor; it will be in bags until washed and returned to the resident. No items will be on the floor. Staff and administrators will do daily monitoring to ensure that this does not occur. In service training will be conducted weekly and daily as needed until the formalized training starts in March of 2026, when documentation will be kept. The administrator is responsible for compliance in all areas of the facility.

Licensee's Proposed Overall Completion Date: *03/31/2026*

Implemented [redacted] - 07/21/2026)

105f - Labeling/Return of Clothes

29. Requirements

2600.
105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

105f Labeling/Return of Clothes *(continued)*

Description of Violation

The home does not have a system to safeguard resident laundry from loss. Resident clothing is unlabeled and stored on unlabeled open shelving in the basement.

Plan of Correction ***Directed [redacted] - 03/18/2026)***

We are in the process of purchasing additional bins to place residents' belongings/clothes on these shelves so that the items will not be lost or misplaced. The expected completion date is April 30, 2026. Pictures will be provided. On an ongoing basis, since immediately after the inspection, the staff have been receiving direction on how to prevent issues with residents' belongings. Formalized training will begin before the end of March 2026, and each quarter thereafter, documentation of these trainings will be kept in the staff and administrator files in the office's lock cabinet. Thus, topics where violations occurred will be covered in training. Administrators are responsible for compliance with the 2600.

Proposed Overall Completion Date: 04/30/2026

Directed Plan of Correction: *within 7 calendar days of the receipt of this plan of correction, the administrator or designee shall ensure that laundry that is brought from the resident rooms to the laundry area is in a laundry basket or other container that is identified with the residents name. The administrator or designee shall ensure that all resident laundry is returned to the resident within 24 hrs.*

Directed Completion Date: *04/01/2026*

Implemented [redacted] - 07/21/2026)

107b - Emergency Procedures

30. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:

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

Description of Violation

The home's written emergency procedures do not include contact information for each resident's designated person, the home's plan to provide the emergency medical information for each resident that ensures confidentiality, duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.

Plan of Correction ***Directed [redacted] - 03/18/2026)***

In each resident folder, there is a form that provides demographic contact information and the next of kin. There is another form that covers transfers to hospitals and shows meds, diagnosis, allergies, and contact person (see forms). These forms holds the information required on the emergency procedures and kept copies of these are in each folder and in a binder in the medication cabinet, easy access if needed in an emergency these information include current

107b - Emergency Procedures (continued)

medication diagnosis next of kin case manager is set to allow for compliance on their emergency procedures [C forms] proposed completion date 3/31/2026 the administrator is responsible for the overall adherence to this rule formal training of all staff will start on March 2026. Subsequently, each quarter we'll have formal education, and documentation will be kept. Audits of resident folders will be done every quarter as well. Documentation will be kept in a locked area, and the administrator or designee will address deficiencies.

Proposed Overall Completion Date: 04/30/2026

Directed Plan of Correction: *Within 7 calendar days of the receipt of this plan of correction, the administrator or designee shall create or update the homes emergency procedures to include a list of all current residents, their respective emergency contacts or designated person as well as the home's plan to provide the emergency medical information for each resident that ensures confidentiality, contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents, means of transportation in the event that relocation is required, and duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs. The administrator or designee shall be responsible for updating this information as the resident/contact information changes, and this plan shall be reviewed at least every six months to ensure accurate information is available in one easy to access location such as a binder or folder that can be quickly obtained in an emergency.*

Directed Completion Date: *04/01/2026*

Implemented [redacted] - 07/21/2026)

107d - Procedure Emergency Management Agency Submission

31. Requirements

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

Description of Violation

The home's written emergency procedures were submitted on [redacted]. The home could not provide proof of prior submission.

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

This violation occurred because the designee could not locate a copy of the report that was submitted for 2024. In the future, the designee will make a hard copy of the report and keep it in the files.

Licensee's Proposed Overall Completion Date: *03/09/2026*

Implemented [redacted] - 07/21/2026)

121a - Unobstructed Egress

32. Requirements

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

Description of Violation

On [redacted] at 9:35 AM, a padlocked chain blocked egress from the home's backyard gate. This gate is considered an emergency egress from the property.

121a Unobstructed Egress (continued)

On [redacted], at 10:28 AM the first floor front egress on the [redacted] side could not be opened. There was no way to unlock the door from the inside to exit the premises.

On [redacted] at 6:50 AM, a padlocked chain blocked egress from the home's back yard gate. This gate is considered an emergency egress from the property.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

On the obstructive egress chain was removed from the back gate on 1/21/2026 after the inspector's visit. Brown Iron Works Company will install a new gate, and a copy of the invoice and documentation for this gate has already been given to the inspector. Due to weather conditions, the final fixtures, including a panic bar, have not been attached to the gate yet. However, it is anticipated that the panic bar will be attached by Tuesday, March 17th or 18th. Once this is done, pictures will be provided to the inspector. To ensure proper compliance in this area, daily monitoring of the .gate will be conducted by all staff within the facility. Staff have been instructed and the adminisrator will also continue to do this so make sure the gate is operable at all times there are two plots in the 1st plots in the facility only this side where the car is which is the bigger gate will there ever be a chain the other side there is what's called a panic bar that it residents will press to go in and out of the gate freely. [Pictures will be provided immediately the bar is in place.] Until then, no chains will be used on the gate. Formalized training on the need for clear emergency egress will be done in March 2026. Documentation will be placed in the staff and administrative folders and in the lock cabinet in the office. The administrator is responsible for complete compliance in the facility.

Licensee's Proposed Overall Completion Date: *03/31/2026*

Not Implemented [redacted] - 07/21/2026)

123b - Emergency Procedures Posted

33. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 03/23/2026)***

The emergency procedures were immediately added to the bulletin board in the back, and the administrator and designee will do weekly monitoring to ensure that the proper postings are still in place [see pictures]. The administrator and designee will do weekly walkthroughs, and whenever there's a deficiency, it will be addressed immediately, and staff will be instructed on what to look for. Formalized training will start in March 2026. Documentation will be kept in the staff's folders in the office's lock cabinet, and each month until June 2026, training will be provided to staff on violations and specific matters related to the home. Quarterly audits will begin in March and June. September and December moving forward to prevent any recurrence of this type of violation. The administrator is responsible for compliance.

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

Not Implemented [redacted] 07/21/2026)

125a - Combustible Storage

34. Requirements

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

Description of Violation

On [redacted] a large white towel was under the stove/oven in the kitchen. In the back hall on the [redacted] side there were plastic bags and containers laying against the heater which has hot to the touch. In the office there were stacks of papers leaning against the heater which was hot, and papers and bags covered most of the walkable area in the office.

Repeat violation: [redacted]

Plan of Correction ***Directed [redacted] - 03/23/2026)***

The white towel under the stove was removed. The violation immediately occurred. The plastic bags and containers near the baseboard heaters were moved immediately. The office was cleared of stacks of papers, and staff received information on combustible items (see Pictures of the office and hallway). Formal training will start in March 2026 and continue each month until June 2026. Other training sessions will be held quarterly, beginning in March 2026. All documentation will be placed in each staff folder, and the files will be securely locked away. The administrator is responsible for ensuring continued compliance.

Proposed Overall Completion Date: 03/18/2026

***Directed Plan of Correction**: In addition to the above POC and within 7 calendar days of the receipt of this POC, the administrator or designee shall audit all areas of the home, at least weekly to ensure ongoing compliance. Any areas of non-compliance shall be corrected immediately upon discovery.*

Directed Completion Date: *03/18/2026*

Not Implemented [redacted] - 07/21/2026)

131f Fire Extinguisher Inspection

35. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the dining area has not been inspected by a fire safety expert since [redacted]. The fire extinguisher in the basement of the [redacted] side has not been inspected since [redacted].

Plan of Correction ***Accept [redacted] - 03/23/2026)***

The inspection of the extinguishers in the [redacted] building was done. The inspection was conducted on 1/30/2026 [see pictures of the receipt and tagged extinguishers]. These extinguishers were out of compliance because of a special regulation that required them to be updated every 10 years. The invoice and payment are required to get this into compliance. In the future, the administrator is responsible for ensuring that this 10-year issue is addressed before the fire extinguisher's expiration date. All staff members will be trained on this new system by March 2026. Documentation and audit training will begin, and documentation will be kept in the folders in the office's locked file cabinet. Also, the administrator will monitor to ensure all extinguishers are serviced by November each year. The administrator and designer responsible for continued compliance are on-site.

Licensee's Proposed Overall Completion Date: *03/15/2026*

Implemented [redacted] - 07/21/2026)

132b Safety Inspection/Fire Drill

36. Requirements

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

Description of Violation

The home could not provide documentation of when the 2024 and 2025 fire safety inspection and drill observed by a fire safety expert was conducted.

Plan of Correction ***Accept [redacted] - 03/23/2026)***

Moving forward, fire safety inspections and fire drills will be conducted annually to prevent violations in both areas of the regulations. The plan is to have the fire department conduct the drill by April 15, 2026, to coincide with the completion of the ongoing renovations. The administrator plans to visit the local fire department to request a visit to the home to fulfill this requirement. The administrator plans to schedule an annual visit by the fire department or another fire safety expert to conduct the inspection, witness the drill, and sign and document the required paperwork. Once the proposed drill has been completed, the administrator will place the information in the fire drill log and immediately write a note in that log to plan the next inspection within 45 days of the anniversary of the last observed drill and safety inspection. The scheduled training of all staff will start before the end of March 2026. Training will be monthly until June 2026 and quarterly thereafter, with audits each quarter. The administrator is responsible for ensuring compliance in this area moving forward.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented [redacted] - 07/21/2026)

132e - Fire Drill Sleeping Hours

37. 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 [redacted] at 11:00 PM. The previous sleeping hours fire drill was conducted on [redacted] at 11:23 PM.

Plan of Correction ***Accept [redacted] 03/23/2026)***

So, to fulfill the requirements for the fire drill during sleeping hours, a fire drill was done on February 20, 2026, by staff. The next sleeping hour drill will be in August 2026, and the next one will be 6 months after that. Staff have received informal training on this violation and the need to ensure that, going forward, these drills are conducted on time. Formalized training education on the needs of these drills will be done in March 2026. Documentation will be placed in each staff folder, and we will keep it locked in the office. Quarterly audits of the home files will ensure continued compliance. The administrator is responsible for ensuring continued compliance.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented [redacted] - 07/21/2026)

141b1 - Annual Medical Evaluation

38. Requirements

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

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted] The resident's previous medical evaluation was completed on [redacted]

Plan of Correction ***Accept[redacted] - 03/23/2026)***

All resident medical evaluations review audits will be conducted by the end of March 2026. To ensure that the forms and items are in each folder, a checklist of requirements will be used. Any folder with deficiencies will be marked with' a sticky paper' with notes on the items that are missing or incomplete. Any deficiencies will also be reflected on the checklist. Based on the audits, we will make all necessary corrections to each folder and ensure all dates and signatures are in the proper place on all forms. After the files are audited, the audit results will be placed in the administrator file, and the resident file will be corrected to reflect the proper information. As part of the audit, due dates for DME, the annual medical evaluation, the Rasp due date, and other required annual forms will be documented on the checklist and kept in each resident's folder. In the future, all resident files will be audited quarterly, and documentation of those audits will be kept. Any deficiencies will be addressed at that time, and documentation will be kept. The administrator is responsible for compliance and ensuring that all required forms are completed properly and are in each resident's folder. The start date for this new system will be March 2026, with quarterly updates thereafter. Any inspection violations in resident files will be corrected right after the March 2026 audit, and any required new forms will be added and be available to the inspector at that time. The administrator hopes to have all files corrected by the first week of April 2026.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Not Implemented[redacted] 07/21/2026)

144c2 - Smoking Area Distance

39. 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 in the backyard. However this area contained pieces of plywood, piles of dried leaves, and trash accumulated on the ground around on [redacted]

Plan of Correction ***Accept[redacted] - 03/23/2026)***

The staff will monitor the smoking area daily. Staff will remove any debris daily. New pails and another trash can with a lid were placed in the smoking area (see pictures) to prevent cigarettes from being left on the ground. Any debris will be removed from the area immediately to prevent a possible fire hazard. Informally, a daily check of the smoking areas is being conducted to prevent issues, and the area is cleaned daily. Starting in March 2026, quarterly training will be provided to staff to ensure compliance documentation or training is kept in the staff folders in the locked office area. The administrator is responsible for compliance in the home.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented[redacted] - 07/22/2026)

162e - Menu Changes

41. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On [redacted], assorted pizza and peanut butter and jelly sandwiches were listed on the menu for the lunch meal. Tuna fish sandwiches and peanut butter and jelly sandwiches were served instead. No notice was provided to the residents in advance of the meal.

Plan of Correction ***Accept ([redacted] 03/23/2026)***

The staff inadvertently substituted tuna for lunch instead of the posted pizza or peanut butter and jelly. The substitution was incorrect because a notice of the change should have been posted before the substitution, so all residents in the house would have been aware of it before coming to the table. In the future, menu changes will be made in advance, and documentation of the substitution will be kept in the administrator's file in the office, amongst the menu forms. The issue was addressed with all staff after the inspection. Formalized training on menu substitutions and other issues within the house will be discussed and documented starting March 2026, informally weekly and more formally every quarter. Documentation will be kept of this issue. The administrator is responsible for compliance within the home. Also, at the beginning of the week, to prevent any such infraction, the administrator or the designee will check the supplies to ensure all items are available within the home, and, if not, will purchase them before the date of use. This will be covered in the formal training beginning in March 2026, and the audit will be done quarterly and documented properly.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented [redacted] - 07/21/2026)

182b - Prescription Medication

42. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

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

Description of Violation

On [redacted] at 7:00 AM staff person A administered medications to residents to include the following; [redacted], and [redacted] tablet to resident [redacted] Staff person A is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

182b - Prescription Medication (continued)

On [redacted] at 7:00 AM staff person C administered medications to residents to include the following; [redacted], and [redacted] tablet to resident[redacted]. Staff person A is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction ***Accept[redacted] 03/23/2026)***

The violation occurred because the administrator, who is also a trainer, had an emergency and did not audit the staff files on time; as a result, the deficiency was not discovered and addressed before the inspection. In the future, all staff files will be audited quarterly by the administrator(s). Any deficiency will be addressed immediately. If a staff member is out of compliance, the staff member will be appropriately trained, and proof of successful completion, including dates, training source, time spent, and the trainer's qualifications, will be placed in the staff member's folder. Training for all previous med staff will begin in March 2026 and will continue until each staff member has completed the training and med pass with proper documentation of scores. Quarterly audits will be documented and kept in all staff files beginning March 2026 and each quarter thereafter. The administrator/trainer will also audit med-trained staff monthly, starting in April 2026, to ensure compliance in this area. The administrator is responsible for compliance with 2600 regulations.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented[redacted] 07/21/2026)

183b - Meds and Syringes Locked

43. 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 [redacted] at 9:39 AM, 3 blister cards of resident medications were unlocked, unattended, and accessible in the unlocked office on the [redacted] side of the building.

On [redacted] at 10:38 AM, the closet containing medications for all residents of the home was unlocked, unattended, and accessible.

On [redacted] at 7:00 AM the closet containing medications for all residents of the home was unlocked, unattended, and accessible.

Repeat violation: [redacted]

Plan of Correction ***Directed [redacted] - 03/23/2026)***

Starting immediately, staff A is responsible for ensuring that all meds are securely stored in the designated storage area. The outer area of the med cabinet will be locked. Med drawers will be locked. Any meds to be returned to the pharmacy will be locked in the file cabinet, and the cabinet key will be kept securely by staff A until the pharmacy personnel arrive for pickup. Until the chief administrator returns, Staff A is responsible for ensuring complete med compliance within the home. The other staff who have been taken off medication duties will start new training by the end of March 2026. The training will be documented, and these staff will not be allowed to dispense or document medication administration until they complete the medication class, show the scores achieved, the source of

183b - Meds and Syringes Locked (continued)

training, and the credentials of the trainer, and have completed the proper medication observation. The chief administrator and trainer will conduct training for these staff. Monthly medication reviews will begin in March and continue through June 2026, until all med staff have been successfully retrained by the trainer.

Proposed Overall Completion Date: 04/30/2026

***Directed Plan of Correction**: In addition to the above plan, the administrator or designee shall check the home daily on each shift to ensure all medications are kept in an area or container that is locked. The daily audits shall continue for 2 weeks, then weekly thereafter. Documentation of audits shall be kept and made available to the Department upon request.*

Directed Completion Date: *04/30/2026*

Not Implemented [redacted] 07/21/2026)

183c - Refrigerated Meds Locked

44. Requirements

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

On [redacted] at 9:21 AM, [redacted] prescribed for resident [redacted] was unlocked and accessible in the refrigerator in the bottom drawer.

Plan of Correction ***Directed [redacted] - 03/23/2026)***

Staff A received instruction on how to handle medication safely. Staff A will ensure all medication is safely stored in the locked cabinet in the office until the pharmacy personnel arrive to remove it/them from the home. All staff will begin formal medication training per 2600. The training will start in March 2026 and continue until June 2026, with quarterly training going forward. Documentation will be kept in each staff member's folder and also in the administrator's records. The home administrators will be responsible for assuring compliance in the home. The med trainer will also train staff to become practicum observer (s) to help with medication audit issues.

Proposed Overall Completion Date: 04/30/2026

Directed Plan of Correction: In addition to the above plan, the administrator or designee shall check the home daily on each shift to ensure all medications are kept in an area or container that is locked. The daily audits shall continue for 2 weeks, then weekly thereafter. Documentation of audits shall be kept and made available to the Department upon request.

Directed Completion Date: *04/30/2026*

Implemented [redacted] 07/21/2026)

183d - Prescription Current

45. Requirements

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

183d - Prescription Current *(continued)*

Description of Violation

On [redacted], [redacted] prescribed for resident [redacted] was in the home's unlocked office; however, the home does not have a current order for this medication for this resident.

Plan of Correction ***Directed [redacted] - 03/23/2026)***

Staff A received instruction on how to handle medication safely. Staff A will ensure all medication is safely stored in the locked cabinet in the office until the pharmacy personnel arrive to remove it/them from the home. All staff will begin formal medication training per 2600. The training will start in March 2026 and continue until June 2026, with quarterly training going forward. Documentation will be kept in each staff member's folder and also in the administrator's records. The home administrators will be responsible for assuring compliance in the home. The med trainer will also train staff to become practicum observer (s) to help with medication audit issues.

Proposed Overall Completion Date: 04/30/2026

Directed Plan of Correction: *In addition to the above plan for training, within 7 calendar days of the receipt of this plan, the administrator or designated person qualified to administer medications will review all current residents' MAR's, prescription orders, and medications to ensure all prescribed medications are available and that any expired or discontinued medications are removed from the medication storage area and kept in a secure location until the pharmacy can pick up. A weekly audit of the medication storage area shall continue there after. Documentation of the audits shall be kept and made available to the Department for review upon request.*

Directed Completion Date: *04/30/2026*

Not Implemented [redacted] 07/21/2026)

183e - Storing Medications

46. 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 [redacted] an unlabeled and undated Arnuity inhaler, was sitting on top of a dresser in a resident room on the 3rd floor. According to the manufacturer's instructions unused portions of this medication should be discarded 6 weeks after opening.

On [redacted] an undated Trelegy inhaler that belonged to resident 2 was in the home's medication room. According to the manufacturer's instructions, unused portions of this medication should be discarded 6 weeks after opening.

Repeat violation [redacted]

Plan of Correction ***Directed [redacted] 03/23/2026)***

After the violation was given, the staff member Af removed the expired, outdated medication from the home by hand and returned it to the pharmacy personnel. Until further notice, Staff A is responsible for ensuring that all

183e Storing Medications (continued)

medications are properly handled in the home, making sure the cabinets are locked, making sure that the medication storage area and storage closet are locked at all times, including the drawers, and removing any outdated medications according to our in home regulations and also 2600. For any self administered medication, staff will re educate residents weekly or more frequently if needed to ensure medications are stored and disposed of properly. This change will start immediately and will be an ongoing formal training program for all staff. Medication handling will begin in March and continue through June 2026. Documentation of these trainings will be kept in the staff folders and in the administrator's files, which are locked in the office cabinet. The administrator and Med trainer are responsible for ensuring medications are handled properly so that no further violations are uncovered. Quarterly audits will start in March 2026, and documentation of these audits will be kept.

Resident 2. In the future the administrator or designee will monitor the self administered medication to ensure that they are disposed of according to the manufacture's instructions.

Proposed Overall Completion Date: 04/30/2026

Directed Plan of Correction: *In addition to the above plan for training, within 7 calendar days of the receipt of this plan, the administrator or designated person qualified to administer medications will review all current residents' MAR's, prescription orders, and medications to ensure all prescribed medications are available, are labeled and dated properly, and that any expired or discontinued medications are removed from the medication storage area and kept in a secure location until the pharmacy can pick up or destroyed in an approved manner. A weekly audit of the medication storage area shall continue there after. Additionally, an audit of medications self administered by residents shall be completed weekly to ensure proper storage, labeling and expiration dates are adhered to. Documentation of the audits shall be kept and made available to the Department for review upon request.*

Directed Completion Date: *04/30/2026*

Not Implemented [redacted] - 07/21/2026)

185b - Medication Procedures

47. Requirements

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

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resid[redacted]t who self-administers medication without the assistance of a staff person and stores the medication in [redacted] room.

Description of Violation

The home's procedures for the safe use of medications and medical equipment do not include documentation of the receipt of controlled substances and prescription medications, a process to investigate and account for missing medications and medication errors, and limited access to medication storage areas.

Plan of Correction ***Accept [redacted] - 03/23/2026)***

The home medication policy will be updated by April 15, 2026, to specify how narcotics/controlled countable meds will be handled in the home in the future. (picture will be available) The log showing the number of items received

185b - Medication Procedures (continued)

will be counted at the beginning and end of each shift. Staff must sign off on this log(see policy) showing how to handle controlled countables within the home. The med trainer and trained staff will monitor the records for accuracy. The med trainer must ultimately ensure accuracy. Formal education and training/retraining of staff will begin in March 2026 and continue through June 2026, and each quarter thereafter. Med-trained staff will also monitor weekly to ensure accuracy in this area. Documentation will be kept in staff folders and also in administrator files in the locked cabinet in the office.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented [redacted] - 07/21/2026)

187a - Medication Record

48. Requirements

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident [redacted] is prescribed [redacted] Tablet. However, resident's [redacted] medication administration record does not indicate diagnosis or purpose for the medication.

Plan of Correction ***Accept ([redacted] - 03/23/2026)***

The missing diagnosis for the medication was added to the Mars after the inspector left. In the future, every week starting March 2026, all staff will be trained/retrained on how to handle medications safely, how to complete the MAR properly, and how to ensure that all required documentation is on those MARS. If any item is missing from the MAR, the pharmacy will be contacted. Documentation of this will be entered into the daily log immediately, and any required new logs will be requested and added to each resident's file to ensure continued compliance at all times. In March of 2026, all staff will begin receiving retraining on proper medication handling. Documentation of these trainings will be kept. Information will be added to each staff folder, showing how many hours of training were covered, who the trainer was, and the trainer's qualifications. This will be added to each staff member's folder, and the administrator will be responsible for ensuring our compliance continues. Moving forward each staff folder along with resident folders MAR and other required forms within the home will be audited by the administrators every quarter results of the audits will be locked in the cabinet in the administrator file in the office any infraction discrepancies will be also noted and will be dealt with immediately documentation will be kept of these as well the administrator is responsible for ensuring complete compliance.

187a - Medication Record *(continued)*

Licensee's Proposed Overall Completion Date: *04/30/2026*

Not Implemented [redacted] - 07/21/2026)

187b - Date/Time of Medication Admin.

49. 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 [redacted] at 8:10 AM, resident [redacted] was administered [redacted], [redacted] and [redacted]. Staff person E did not initial or record the date and time of administration until 8:49 AM after completing medication administration to all residents and at the request of an agent of the department.

On [redacted] at 8:30 AM, staff person E documented [redacted] and [redacted] as administered to resident [redacted], however resident [redacted] was not in the home at that time.

Resident [redacted] is prescribed [redacted]. and [redacted]. Resident [redacted] medication administration record does not include the initials of the staff person who administered these medications on [redacted] at 8:08 AM.

Plan of Correction ***Accept [redacted] - 03/23/2026)***

f Training /retraining for staff to administer meds will begin in March 2026. Each staff will not be able to administer med until a successful result on each test has been achieved. Monthly training will continue from March until June 2026. Once the staff has completed the glass plus the required days of observtion then and only then will that person be allowed to administer any medication. Going forward, audits of records for residents and staff will be done in March, and every quarter thereafter. Results for the audits will be filed into the records in the locked cabinet in the office. Special attention will be given to the MAR'S to ensure accuracy. The med trainer will be responsible for the training and auditing of the records.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Not Implemented [redacted] - 07/21/2026)

221a - Program Activities

51. Requirements

2600.
221.a. The administrator shall develop a program of activities designed to promote each resident's active involvement with other residents, the resident's family and the community.

Description of Violation

The home does not have a program of activities designed to promote the active involvement of residents with families and the community. The home had no activities planned for [redacted] and [redacted]

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

This violation occured because the administrator and designee failed to check that the activities plan was completed. Activities were added after the inspection and in the future the administrator and designee will create a program of activities at least two months in advance. This will be ongoing and proof will be available.

Licensee's Proposed Overall Completion Date: *02/24/2026*

Implemented [redacted] - 07/21/2026)

225c - Additional Assessment

52. Requirements

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

Description of Violation

Resident [redacted] assessment, dated [redacted], is blank in the assessment area for managing finances; however, the home manages resident 4's finances.

Resident [redacted]s assessment, dated [redacted], does not include an accurate assessment of the resident's need for managing finances. The home manages resident 5's finances however this area of the assessment is marked as "not applicable"

Resident [redacted]'s assessment, dated [redacted], does not include an accurate assessment of the resident's need for managing finances . The home manages resident [redacted] finances however this area of the assessment is blank.

Plan of Correction ***Accept [redacted] - 03/23/2026)***

All resident folders will be audited starting March 2026. Any discrepancies documented during the recent inspection will be addressed at this time. If additional RASP, DME, and MED EVAL forms are needed, the administrator(s) will complete them and submit them to the inspector to correct the violations. From now on, all files will be audited each quarter, and results will be kept safely in the resident files and also the admin. Records will be locked in the cabinet.

225c - Additional Assessment *(continued)*

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented [redacted] - 07/22/2026)

227e - Self Administer Medication

53. Requirements

2600.
227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident [redacted] assessment, dated [redacted], does not address the resident's ability to self-administer medications. This area of the assessment is marked as "Assistance in offering medication at prescribed times" but does not list a description of how to support the residents medication needs.

Plan of Correction ***Accept [redacted] - 03/23/2026)***

All residents who currently self-administer any medication will be retrained to ensure they can continue to self-administer. The staff will also go over the resident's responsibility to store meds properly so other residents cannot see or use them. All new changes will be implemented following the 1st quarter audit in March 2026. (result should be available 4/10/2026) Any new RASP, DME, MED EVAL forms will be filled out after the 1st audit in March 2026 has been completed (available form should be ready by 4/10/2026). Administrators are responsible for compliance.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented ([redacted] - 07/22/2026)

227g -Support Plan Signatures

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

Plan of Correction ***Accept [redacted] - 03/23/2026)***

The plan is to audit all resident folders, starting in March 2026. At the end of March 2026, the audit results will be retained. A checklist will be placed in each resident's folder showing compliance areas. The administrator will deal with any adjustments or discrepancies, and documentation will be provided. Resident 8 did not participate or did not signed the support plan [redacted] was an oversight on the behalf of the administrator the resident was unable to sign at the time therefore a witness should have been used since the resident did actively participate in developing the plan the signature for the resident should have been witness dated and signed by another administrator or direct care staff. In the future, this will be done promptly. Again, audits will be conducted every quarter on all resident folders, starting in March 2026, and subsequently every quarter thereafter. March, June, September, and December will serve as audit dates for all folders within the home, and copies of these audits will be kept in the resident folders and in the UM administrator's file. Locked away in the office.

Proposed Overall Completion Date: 04/30/2026

Licensee's Proposed Overall Completion Date: *04/30/2026*

227g -Support Plan Signatures *(continued)*

Implemented [redacted] - 07/22/2026)

251b - Record Entries Legible

55. 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

Correction fluid was used on resident's [redacted] assessment and support plan dated [redacted]. [redacted] was written over correction fluid on in both "Date Assessment Finalized" and "Date Support Plan Finalized" sections.

Plan of Correction ***Accept [redacted] - 03/23/2026)***

Major service training for all staff will begin in March. In 2026, thereafter, trainings will coincide with every quarter, and documentation of those trainings and topics covered will be kept in each staff member's folder and in the administrator's file. Covered topics will also be available and will serve as additional training and required training for all staff within the facility. All resident folders will be, or they will try again. Any updates will be made to the documentation will also be kept also no on each resident folder if there are any errors the errors will be corrected with a single line through the arrow followed by the initial of the person making the correction and the proper documentation stating what was bought should have been written or what did Jesus mean to us this will also be dated. The administrator is responsible for ensuring compliance with all risks and folders, as well as all these items.

Licensee's Proposed Overall Completion Date: *04/30/2026*

Not Implemented [redacted] - 07/21/2026)

254c - Records Storing

56. Requirements

2600.
254.c. Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

Description of Violation

Resident records are stored in unlocked filing cabinet with rags and coffee in the [redacted] side back hall. This hall is used by residents to access the back yard and smoking area.

Plan of Correction ***Accept [redacted] - 03/23/2026)***

The office was reorganized, and all records were moved back in the week of January 21, 2026. In-service training for all the care home staff will begin formally in March 2026. Every quarter, beginning March 2026, all resident folders and staff folders will be audited. To ensure daily continuous compliance, the administrator and designee will conduct a walkthrough of the entire facility to verify compliance and accuracy in handling issues documented in the house. The administrator and the designated individual will also monitor human-made entries in our daily log to ensure compliance. Instead, training will be conducted every quarter, or more often if needed, and documentation of these trainings will be kept in the staff folder and in the administrator's file. This will help ensure compliance across all areas of the regulation and issues within the facility. All documentation will be kept in the staff folder and the administrative file, locked away in the office. Um, pictures of this training will be available when needed. Or requested.

254c - Records Storing (continued)

Licensee's Proposed Overall Completion Date: *04/30/2026*

Implemented ([redacted] 07/21/2026)

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

Facility Information

Name: *SCOGGINS PERSONAL CARE BOARDING HOME* **License #**: *14015* **License Expiration**: *10/11/2026*

Address: *1245 WEST TIOGA STREET, PHILADELPHIA, PA 19140*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *EVADNEY SCOGGINS*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *03/14/2024* **Issued By**: *City of Philadelphia*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *12* **Waking Staff**: *9*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *05/07/2026*

Inspection Dates and Department Representative

05/07/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served**: *12*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *12* **Are 60 Years of Age or Older**: *10*

Diagnosed with Mental Illness: *11* **Diagnosed with Intellectual Disability**: *1*

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

Inspections / Reviews

05/07/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/08/2026*

06/18/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/11/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/23/2026*

07/21/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/28/2026*

Reviewer: [redacted] **Follow Up Type:** *Bypass Document Submission*

07/22/2026 Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *07/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Enforcement*

51 - Criminal Background Check

1. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A began working as a volunteer providing direct care to residents in the home in January 2026. The home does not have documentation that a criminal background check was completed prior to or on the date of hire.

Plan of Correction ***Accept [redacted] - 06/29/2026)***

Starting June 2026 the administrator/designee will be using the attached check list to audit all staff records(see attached) staff requirement sheet. As of June 2026 the administrator will be auditing all staff folders on a monthly basis until the end of 2026. Starting 2027 all staff folders will be audited by the administrator or designee to ensure compliance. ,Result of audit will be kept in the administrator records.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Not Implemented [redacted] - 07/21/2026)

54c - Volunteer

2. Requirements

2600.
54.c. A volunteer who performs ADLs shall meet the staff person qualifications and training requirements specified in this chapter.

Description of Violation

Volunteer staff A assists residents with activities of daily living including assisting showers. The volunteer does not meet the staff person qualifications and training requirements specified in this chapter in accordance with 2600.54a and 2600.65.

Plan of Correction ***Accept [redacted] - 06/29/2026)***

As of June 2026 the administrator will be using the attached check list to audit all staff records to ensure compliance(see attached). Monthly audits on the staff folders will continue by administrator/designee until December 2026. In 2027 and beyond staff folders will be audited quarterly by administrator/designee. copies of the audits will be placed in each staff folder and also in the administrator's records.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Not Implemented [redacted] - 07/21/2026)

82a - Poisonous Materials

3. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

82a - Poisonous Materials *(continued)*

Description of Violation

There was an open and unlabeled white bucket containing a dry blue powder, in the basement of the home. According to staff B, the bucket contained laundry detergent powder; however, the home could not provide the original product label.
There was an unlabeled, unidentified white spray bottle containing an unknown clear liquid on the windowsill next to the sink in the kitchen.

Plan of Correction ***Accept ([redacted] - 06/29/2026)***

Starting June 2026 the administrator or designee will be doing monthly audits of the facility to ensure poisonous chemicals are being handled and stored properly. A new audit check list (see attached) will be used. Copies will be stored in the administrator records. As a constant reminder to all staff poisonous material/chemical notice are posted in the laundry area, the door or the store room and also in the kitchen (see attached) Administrator/Designee will be responsible for continued compliance. and the administrator will keep copies of quarterly audits. as well starting 2027.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Not Implemented [redacted] - 07/22/2026)

82b - Poisonous Material Storage

4. Requirements

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

Description of Violation

There was an open tube of silicone caulk with a warning label indicating, "CAUTION! Uncured sealant irritates eyes, skin, and respiratory tract. If swallowed, do not induce vomiting, seek medical attention," sitting on the windowsill behind the kitchen stove.

Plan of Correction ***Accept [redacted] - 06/29/2026)***

Immediate plan - Starting May 2026 the administrator and designee have been doing weekly checks to ensure compliance and enforcing 05/08 26 poisonous material training. Weekly audit will continue for the remainder of June and July 2026 by the administrator/designee.. Then after that audits will be monthly then quarterly audits will be conducted by the administrator / designee and the outcome will be kept by the administrator who is responsible for ensuring compliance in the home.

Licensee's Proposed Overall Completion Date: *06/25/2026*

Not Implemented [redacted] - 07/22/2026)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On 05/07/2026 around 09:30 AM, following unsanitary conditions were observed in the home:

- *the windowsill behind the kitchen stove was noticeably dirty with dust, grease, and grime.*

85a Sanitary Conditions (continued)

- *the toaster in the kitchen was visibly dirty with a greasy front surface.*
- *the back bedroom on the 1st floor-45 side, occupied by 3 residents, smelled heavily of feces. There were no*
- *residents present in the room.*

Plan of Correction ***Accept [redacted] - 06/29/2026)***

1. On a daily basis housekeeping staff will clean and sanitize all areas of the house administrator /designee will monitor weekly.
2. As mentioned previously toaster will be cleaned daily after use by kitchen personnel or administrator or designee (a posting is above the toaster to remind everyone about cleaning it) see proof
3. Hand dryer was replaced on 05/08/26 and all hand dryers will be checked daily by staff (see housekeeping audit schedule)
4. From June to December 2026 the admin and staff will monitor sanitary conditions in the home daily.
5. Starting January 2027 onwards admin/designee will do quarterly audit (see audit check sheet)to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Not Implemented [redacted] - 07/22/2026)

85e - Trash Outside Home

6. Requirements

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

Description of Violation

There was trash along the ground at the back wall next to the smoking area including an old sink, buckets, shoes, and a broken weed whacker.

Plan of Correction ***Accept [redacted] - 06/29/2026)***

Trash area in the back will be monitored and cleaned daily by staff. At the end of each shift administrator or designee will again check to ensure all trash is properly packed away.

The area will be checked daily by staff to ensure all trash is properly contained in the cans not on the ground.

When needed the entire area will be swept by staff so that no "butts" or other debris remain on the ground.
Any corrective actions needed will be brought to the attention of the administrator or designee and will be corrected immediately and documented in the daily log book (see current pictures)

Licensee's Proposed Overall Completion Date: *06/25/2026*

Not Implemented [redacted] - 07/22/2026)

87 - Lighting

7. Requirements

2600.
87. Lighting - The home's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

There was no lighting in the hall between the second floor fire exits.

Plan of Correction ***Accept ([redacted] - 06/18/2026)***

The light bulbs throughout the hallways were changed to "daylight" bulbs (see proof) to give off a brighter light.

To prevent any further infractions the administrator will monitor weekly and keep extra supplies on hand

Licensee's Proposed Overall Completion Date: *06/07/2026*

Not Implemented ([redacted] - 07/22/2026)

88a - Surfaces

8. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On [redacted], following unclean and unsafe surfaces were observed:

- *the door handle of room [redacted] on the 45 side is not secure in the door and can easily be pushed through*
- *there are metal nails sticking out of the radiator on the 2nd floor-45 side and the floor near the radiator is uneven, covered in built up dust and dirt*
- *there are metal nails sticking out of the radiator on the 3rd floor- 45 side, and the radiator and flooring in the area is covered in dusty dirt and there are loose floor tiles in the hallway crossing over to the 43 side.*
- *there is a long nail sticking out of the front of the 1st floor-45 side bathroom door, at eye level*
- *the light cover in the ceiling in the front bathroom is yellowing and full of cracks and there are multiple circular brown water stains on the drop ceiling tile next to the ceiling light.*

Plan of Correction ***Accept [redacted] 06/18/2026)***

As of May 8, 2026, all the listed items were fixed. To prevent these infractions in the future the administrators will be doing weekly checks and addressing the issue(s) immediately.
The administrator is responsible for ensuring compliance. The administrator or designee will monitor daily and will fix hazards as they are noticed when outside help is needed the administrator will find the help asap.

Licensee's Proposed Overall Completion Date: *06/07/2026*

Not Implemented [redacted] - 07/22/2026)

89b - Hot Water Temperature

9. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

89b - Hot Water Temperature *(continued)*

Description of Violation

The hot water temperature at the bathroom sink on the 2nd floor of 45 side measured 125 degrees Fahrenheit at 9:30am,
The hot water temperature in the 3rd floor bathroom sink measured 129.2 degrees Fahrenheit at 9:36am.
The hot water temperature in the 1st floor -bathroom measured 132.2 degrees Fahrenheit at 11:38am.

Plan of Correction ***Accept ([redacted] 06/29/2026)***

Since June 2026 the staff in the home has been checking the water temperature daily and and will be logging abnormal temperatures in the homes daily log book. Also since June 2026 we have been using our new(see attached) temperature log to monitor the temperature weekly. The log shows date, location, responsible individual(s) ,temperature , corrective action if needed and time the checking was done. copies of the logs will be kept in the office. At the end of July 2026 the administrator plans to switch to unofficial daily monitoring by administrator or designee then monthly official documented monitoring until the end of December 2026. In 2027 the administrator will begin quarterly monitoring of the logs .Copies of all logs will be kept in the administrators records. the administrator will continue to ensure compliance in the home.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented [redacted] - 07/22/2026)

92 - Windows

10. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

The window in the 3rd floor-45 side bathroom is open. The screen is broken on the right side and it is covered in dust.

Plan of Correction ***Accept [redacted] 06/29/2026)***

The window was fixed on 5/8/2026 by staff. Since June 2026 the administrator has implemented new checklist for duties within the home(see attached) The new checklist indicates the things that must be done by specific staff when working in the home. The administrator/designee is then responsible for following up by checking rooms, bathrooms, hallways , beds, furniture to ensure cleanliness and that all in in good condition and appropriate working order. Officially the administrator/designee will sign off on the logs weekly until the end of July 2026 afterwards to the end of December 2026 the administrator will change to weekly oversight and written monthly checklist documentation (see attached). Beginning January 2027 quarterly audits will be done by the administrator/designee and records will be kept in the administrators files.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Not Implemented [redacted] - 07/22/2026)

95 - Furniture and Equipment

11. Requirements

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

Description of Violation

The sink in the 3rd floor -45 side bathroom is clogged full of cloudy, dirty water and not draining.

95 - Furniture and Equipment (continued)

In resident room [redacted] on the 3rd floor-45 side, the arm chair is broken and it is sunken down in the middle of the seat.

Plan of Correction ***Accept [redacted] - 06/18/2026)***

The maintenance person did clear the blockage in the sink on 05/07/26. The sink was cleaned and sanitized. going forward starting 05/08/26 on a monthly basis drain cleaner will be used in each sink.

Rm #6 The chair was removed on 05/07/26
Admin. will monitor weekly to maintain compliance

Licensee's Proposed Overall Completion Date: *06/07/2026*

Not Implemented [redacted] - 07/21/2026)

100a - Exterior - Free of Hazards

12. Requirements

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

Description of Violation

On [redacted], following hazardous conditions were observed:

- *The ground near the back metal gate which is used as an emergency exit from the property, is uneven and broken both in front of and behind the gate and there are weeds growing out of and around it. Under the gate is a small concrete ramp about 4 inches long which is also cracked, broken and weedy.*
- *On the ground, outside of the front door, there is a black plastic door mat that is torn into 4 pieces. Some of the pieces are overlapping each other creating an uneven surface for walking.*
- *The smoking area patio is surrounded by various pieces of plywood on the ground and leaning against the roof support poles. Some of the wood has rusty nails poking through it, some pointing in towards the benches that residents use to sit in to smoke.*
- *In the back patio area and smoking area there are unsecured raggedy old tarps dangling from fencing and from the smoking roof and flying into the area when wind blows. There are random stacks of wood in front of some of the tarps. The wood appears to be moldy, wet and rotting.*
- *There is broken plexiglass behind one of the benches in the smoking area and an old wooden head board on the ground.*
- *The brick patio under the smoking awning has sand put down to fill some of the cracks and spaces between the bricks but the patio is very uneven and poses various tripping hazards.*

Plan of Correction ***Accept [redacted] - 06/29/2026)***

Currently the entire back yard is being checked daily by staff and administrator.
The entire back yard has been cemented by S&S construction company as of 6/13/2026 (see pictures)
The roof was replaced and painted by 06/13/26 the only wood used in the structure is in the roof area. (see pictures,).

Weekly administrator will be checking the structure, new wires, new privacy screens to ensure they are hazard free and in good working order; If corrective action is needed S & S Construction will be notified immediately and the administrator will document the issue in the home daily log notes and ensure any fixing is done as soon as

100a - Exterior - Free of Hazards (continued)

possible, time and date will be documented.

Every quarter after December 2026 the administrator will update and document the upkeep of the back yard/area.

Licensee's Proposed Overall Completion Date: *06/25/2026*

Implemented [redacted] - 07/21/2026)

101j1 - Mattress Fire Retardant

13. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

Room [redacted] is occupied by 3 residents. The resident's mattresses are in poor condition, sinking in the middle and can not adequately support a resident.
The back bedroom on the 1st floor-45 side is occupied by three residents and has 4 mattresses which are all covered in plastic.
In resident room [redacted] on 45 side, one of the residents' bed's boxspring was covered in plastic.

Repeated Violation - [redacted]

Plan of Correction ***Accept [redacted] - 06/18/2026)***

05/10/2026 mattresses were replaced in room [redacted]
05/07/2026 The plastic was removed from all mattresses on the first floor of the -45 side.
05/10/2026 all plastic on the mattresses and box springs were removed.
Administrator will monitor weekly to prevent further violations. See pictures

Licensee's Proposed Overall Completion Date: *06/07/2026*

Not Implemented [redacted] - 07/22/2026)

101j2 - Bedroom Chairs

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

Resident room [redacted] on 45 side is occupied by two residents; however, there is only one chair in the room.

Plan of Correction ***Accept [redacted] - 06/29/2026)***

As was indicated in 92a the administrator has now implemented a new checklist will be available for all staff to use when cleaning or monitoring the home (see attached).

Since May 2026 the administrator and other staff have been making daily checks of all rooms. We have been checking beds, linen, flooring, chairs, lamps etc.. and will continue doing this daily until July 2026. After July 2026 documentation (formal) will be done monthly however, the administrator will continue to do daily checks (see list).

101j2 Bedroom Chairs (continued)

Every quarter the administrator will document any issue which arise and keep records in administrators files..

Licensee's Proposed Overall Completion Date: *06/25/2026*

Not Implemented (- 07/22/2026)

101j3 - Bed/Linens/Pillows/Blankets

15. 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

In resident room (2nd floor front) shared by 3 residents, all of the pillows on the beds are stained with dark spots appearing to be old evidence of bed bugs.
The bed linens on all the beds are thread bare and heavily stained.
The far bed has a white comforter covered in holes.

In the room at the top of the third floor on the 45 side, shared by 3 residents, all bedding and sheets have holes and what appears to be blood stains.

Repeated Violation -

Plan of Correction ***Accept - 06/18/2026)***

After the inspection, beginning on 05/10/2026 we have replaced all linens in the home. Extra linens were purchased to supplement supplies. See pictures. The administrator will conduct weekly monitoring to ensure that proper linen is being used and disposing of any damaged items.

Licensee's Proposed Overall Completion Date: *06/07/2026*

Not Implemented (07/22/2026)

101j7 - Lighting/Operable Lamp

16. Requirements

2600.
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

In resident room (2nd floor front), which is shared by 3 residents, the bedside lights above the beds do not turn on and there are no other lights within reach.
In resident room on 45 side, the bedside lights above the two beds do not work and there are no other lights within reach.
In the room at the top of the third floor on 45 side, shared by 3 residents, the bedside light above two of the of three beds do not work.

Repeated Violation -

Plan of Correction ***Accept - 06/29/2026)***

As of 6/3/2026 new bedside touchable lamps were placed beside the beds for residents to use. (see attached) . The

101j7 Lighting/Operable Lamp (continued)

new cleaning checklist which has been set in place by the administrator list all items that Must be checked by staff daily including, beds ,chairs, lamps. (see attached) . The administrator/designee makes daily checks of the home to ensure continued compliance within the home. On a weekly basis the administrator/designee will document the results of the weekly checks and keep documentation. If corrective actions is needed at any time the administrator will get the issue fix asap. Starting 2027 the administrator will cover fixtures and furniture in the quarterly audits and keep results in the administrator's files.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Not Implemented [redacted] - 07/22/2026)

101o - Walls, Floors, Ceilings

17. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The floor in second floor front bedroom [redacted] was uneven and was splattered with an unknown brown substance.
A floor plank located in the room at the top of the third floor on the 45 side was observed to be in poor condition. It was pushed down, or broken off in places and not flush with surrounding planks. It appeared to have been painted over multiple times further creating an uneven surface and posing a tripping hazard.

Plan of Correction ***Accept ([redacted] 06/18/2026)***

In 1245 side, Room [redacted] s flooring was replaced on 06/05/2026. See proof.

06/05/2026 Room [redacted] on 3rd floor front has been fixed by workers from SNS Construction. See pictures.
Administrator will monitor weekly for continued compliance and will ensure all problems are fixed as needed.

Licensee's Proposed Overall Completion Date: *06/07/2026*

Not Implemented ([redacted] - 07/22/2026)

102h - Toilet Paper

18. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

There was no toilet paper for the toilet in the 3rd floor bathroom of 45 side.

Repeated Violation [redacted]

Plan of Correction ***Accept [redacted] - 06/18/2026)***

As of May 7, 2026, tissue paper was immediately placed in the 3rd floor bathroom on the 45 side. Designee and maintenance will ensure, daily, that all bathrooms have toilet paper. Moving forward, we have implemented a checklist for all staff to complete each and every time they work. Administrator and designee will monitor the building to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/07/2026*

102h - Toilet Paper *(continued)*

Not Implemented [redacted] 07/22/2026)

102i Soap Dispenser

19. 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

There was no soap in each of the following locations:

- *the 3rd floor-45 side bathroom*
- *the 2nd floor-45 side bathroom*
- *the 3rd floor-43 side bathroom*

Plan of Correction ***Accept [redacted] - 06/18/2026)***

On 06/02/26 all soap dispensers were changed throughout the building which makes it much easier to see the level of soap in the dispenser so they can be replaced in a timely manner.

The administer will ensure continued compliance by checking weekly.

Licensee's Proposed Overall Completion Date: *06/07/2026*

Not Implemented [redacted] - 07/22/2026)

103i Outdated Food

20. Requirements

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

Description of Violation

There was an unlabeled, undated bin containing loose cornmeal on a shelf in the basement.

Repeat Violation - [redacted]

Plan of Correction ***Accept [redacted] - 06/18/2026)***

The cornmeal was immediately disposed of on 05/07/26.. A new policy was implemented; all items must remain in the original package and placed in protective buckets, tubs or container and dated once opened. staff training was done in house on 05/08/26.

Administrator and ServSafe staff will monitor for dailly for compliance.

Licensee's Proposed Overall Completion Date: *06/07/2026*

Not Implemented [redacted] - 07/22/2026)

121a - Unobstructed Egress

21. Requirements

2600.

121a - Unobstructed Egress *(continued)*

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

Description of Violation

In the [redacted] vestibule, the floor is warped and the exit door will not open entirely, partially obstructing the exit, a person would have to turn to the sideways to be able to exit through the opening.

The back door on the first floor 45 side was locked with a dead bolt, which cannot be opened with one hand. The door needs to be pushed into the door frame with force for the dead bolt to be unlocked.

Plan of Correction ***Directed [redacted] - 06/29/2026)***

Currently S&S construction has been renovating and updating issues within the home. In the past neither of these doors have created an issue either for fire drills, EMT or other emergency visits to the home. S&S construction is still working on finding a permanent solution to this issue by the end of July 2026. A proposed plan is to shave the door and adjust the spring which prevents the door from staying wide open. the administrator will continue to monitor the situation and document the outcome by the end of July 2026.

Proposed Overall Completion Date: 07/31/2026

DIRECTED PLAN OF CORRECTION: Within 72hrs of receipt of this plan of correction, the administrator or designee will contact a licensed contractor to completely repair the emergency exit door so that it opens and closes properly and fully until a replacement door or other permanent repair is able to be made by the end of July. Additionally, the administrator or designee shall audit all emergency egress doors at least once a month to ensure proper functioning of all egress doors. Documentation of all repairs and monthly audits for 6 months shall be kept and made available to the Department upon request.

Directed Completion Date: *07/10/2026*

Not Implemented ([redacted] - 07/22/2026)

125a - Combustible Storage

22. Requirements

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

Description of Violation

There is a pile of papers pushed up next to the toaster in the kitchen area.
There is a plastic red/purple cigarette lighter on the floor under the radiator in the [redacted] vestibule.
In the back exit hallway there is a large piece of plywood behind the radiator, as well as various construction items in cardboard boxes on the floor, in close proximity to the radiator and plastic container of joint compound sitting on the radiator.

Repeated Violation - [redacted]

125a - Combustible Storage *(continued)*

Plan of Correction ***Accept (- 06/18/2026)***

05/07/26 the papers were immediately removed. Staff training on these specific issue was done on 05/08/26. Staff were again educated on fire safety especially combustible and flammable materials. The smoking policy was discussed in details. In the future the administrator will monitor daily and any issues will be fixed immediately (see pictures)

Licensee's Proposed Overall Completion Date: *06/07/2026*

Not Implemented - 07/22/2026)

130a - Smoke Detector 15 ft Bedroom

23. Requirements

2600.
130.a. There shall be an operable automatic smoke detector located within 15 feet of each bedroom door.

Description of Violation

A smoke detector on the 3rd floor-43 side is covered in duct tape. The home reports that it was covered to prevent it from going off during the renovations to the rooms on this floor. There is no other smoke detector located in the area or within 15 feet of the rooms in this area.

Plan of Correction ***Accept - 06/29/2026)***

To prevent the above deficiency again the administrator and staff will continue to do daily walk through in the buildings. As of June 2026 all staff have been given checklist to look for specific things/items to ensure compliance within the home. ,The administrator/designee will do daily walk through of the home and document and fix or any problem or find someone to fix the issue immediately. weekly documented check of the home will continue until the end of July 2026 then monthly until December 2026.(see checklist). After July and until December 2026 monthly documented checks will be done by administrator/designee and records will be kept. Starting January 2027 the administrator will start quarterly audits and results and corrective actions will be kept in the administrators records.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented 07/21/2026)

133.1 - Exit Signs

24. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

There is not an exit sign at the door used as an emergency exit in the hall that crosses over from the 45 side to the 43 side. The home currently serves 12 residents.

Plan of Correction ***Accept (- 06/18/2026)***

As of May 8, 2026, additional exit signs were added and are now located at each egress of the home. The administrator will be responsible for ensuring that all exits are properly labeled and visible. Weekly checks will be made as well.

Licensee's Proposed Overall Completion Date: *06/07/2026*

Implemented - 07/21/2026)

141b1 - Annual Medical Evaluation

25. Requirements

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

Description of Violation

Resident [redacted] most recent medical evaluation was completed on [redacted]

Plan of Correction ***Accept [redacted] - 06/29/2026)***

Audits for residents folders are being done on a quarterly basis. Previous audits was completed at the end of March/April 2026. The next audit will be completed by the end of June 2026 by the administrator and designee (see audit check sheet). Also to ensure that this violation does not happen again . The administrator/ designee will conduct mini compliance checks, to enforce the quarterly audits this will begin July 2026 and monthly thereafter. All audits and checks will be kept in each resident folder. administrator is ultimately responsible for ensuring compliance within the home.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Not Implemented [redacted] - 07/21/2026)

144c1 - Smoking Area Guidelines

26. 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:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home permit's smoking in the smoking area located outside at the back of the home. On [redacted] In resident room [redacted], there are cigarette butts on the floor and the room smells heavily of smoke. There was visible smoke lingering in the room when the door was opened at one point during the inspection. Additionally, the bathroom on the 2nd floor-45 side smells strongly of cigarette smoke.

Plan of Correction ***Accept [redacted] - 06/29/2026)***

Since the inspection the administrator and all staff have been doing daily checks throughout the buildings to ensure compliance. The staff have also been checking resident more vigilantly at the doors to ensure cigars, cigarettes, matches and lighters are being collected when the resident enters the buildings .and stored safely until they are leave the building again start date 5/8/2026 (see attached) all staff will continue daily to do this to protect everyone in the home. New cleaning checklist will help to support this new plan. Administrator/designee will do daily checks going forward and document findings in the daily logs. Monthly monitoring documentation will begin June 2026 and will continue until December 2026 . Starting 2027 the quarterly audits will be kept by the administrator.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Not Implemented [redacted] - 07/22/2026)

144c2 - Smoking Area Distance

27. Requirements

2600.

144c2 - Smoking Area Distance *(continued)*

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 smoking area is surrounded by various pieces of old, untreated plywood on the ground as well as raggedy old plastic tarps dangling from fencing and the smoking area patio awning/roof and flying into the area when wind blows.

Plan of Correction ***Accept ([redacted] - 06/18/2026)***

We have proposal from S&S Construction Company to fix the backyard smoking area, ramp outside and inside gate and all uneven surfaces (see pictures)

1. Complete area with benches have been completely cemented.

2.The tarp has been removed and replaced with new privacy screens. See pictures.

3. Nail hazards have been removed 05/08/2026, see pictures.

4. Broken plexiglass has been removed 05/09/2026. See pictures.

5. The entire yard has been cemented including the former brick area, even the parking area. See pictures.

6. The roof of the structure was replaced and is awaiting painting with fire resistant paint up to 120 degree temperature this will be completed prior to 06/30/206.
7. all the wood was removed and replaced with metal netting/fencing
The Admin/designee will be responsible for week checks to ensure continued compliance

Licensee's Proposed Overall Completion Date: *06/07/2026*

Implemented [redacted] - 07/22/2026)

181d -Storing Medication

28. Requirements

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

Description of Violation

Resident [redacted] self-administers [redacted] nasal sprays and stores medications in [redacted] room. On [redacted] at 11:30 AM, the resident's nasal spray was kept in a chest of drawers, which did not have any locking mechanism. The resident shares the room with another resident who is not capable of self-administering medications.

Plan of Correction ***Accept ([redacted] 06/29/2026)***

After the inspection the administrator did reeducate residents on medication safety and storage. On a daily basis administrator/designee and all staff will be checking to ensure medications being held by resident(s) is being stored away properly.(lock boxes provided). The administrator did call the PCP after the 5/7/2026 to re-assess them on their ability to administer their inhalers safely(see attach 5/11/26) as of now the residents were found to be capable.

181d -Storing Medication (continued)

Immediately 5/8/2026 staff including the administrator will continue daily checks of the residents rooms to ensure compliance and safety. Should resident be noncompliant again the administrator/med tech will notify the PCP and reclaim the responsibility of storing all meds and monitoring and documenting each administration in the future. Starting June 30,2026 medication staff will start formal checks on a daily basis to ensure proper storage of the resident lock boxes to ensure compliance. Administrator is still responsible for overall compliance moving forward.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Not Implemented [redacted] - 07/21/2026)

183b - Meds and Syringes Locked

29. 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

There was an unlabeled bottle of Visine eye drops on the kitchen countertop. There were 3 gray inhalers on the dresser in the back bedroom on the first floor 45 side which is shared by 3 residents.

Repeated Violation - [redacted]

Plan of Correction ***Accept [redacted] 06/18/2026)***

Visine eye drops were not being used by anyone in the home and no resident had such an order. Administrator did dispose of the eye drops on 05/07/26

On 05/08/26 when staff received poisonous/chemical training this violation was also covered.

Residents were educated that pharmacy labels must remain with the medicine at all times. Residents who self administer meds were again educated on proper medication storage

Admin/designee will do daily walk through of all rooms to ensure compliance

Licensee's Proposed Overall Completion Date: *06/07/2026*

Not Implemented [redacted] - 07/22/2026)

184a - Resident's Meds Labeled

30. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

There were 3 gray unlabeled inhalers on the dresser in the back bedroom on the first floor 45 side.

Plan of Correction ***Accept [redacted] - 06/29/2026)***

After the inspection on 5/7/2026 the administrator did call the PCP to assess resident(s) ability to safely self

184a - Resident's Meds Labeled (continued)

administering their inhalers (see attach PCP note) per the PCP they were found to be capable. As of 5/7/2026 the administrator and all staff have been checking residents rooms daily for compliance.(lock boxes in place) As of 6/30/2026 weekly formal documentation will be kept by the administrator/designee to ensure continued compliance. Whenever the administrator finds that compliance is not be adhered to the administrator and med staff will be responsible for returning meds to the home med supply and the med staff will then be responsible for monitoring and documenting the resident while medication is being administered. AS of June 2026 medication audits will be done monthly by admin/med staff and results will be kept by the administrator. Formal audits will be done quarterly by March, June, September and December of each year records will be kept by the administrator.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Not Implemented [redacted] - 07/22/2026)

187a - Medication Record

31. Requirements

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident [redacted] is prescribed [redacted]. However, the resident's May/2026 medication administration record (MAR) listed the dose as [redacted]

Resident [redacted] is prescribed [redacted] and [redacted]. However, the resident's May/2026MAR does not indicate the diagnoses of these medications.

Plan of Correction ***Accept [redacted] 06/29/2026)***

Medication staff started a weekly audit the week of 5/11/2026(see attached med audit checklist). This new checklist shows the audit period, persons responsible for the audit, This new checklist also has a section covering Medication labels matching dose ,pharmacy label vs physician orders basically making sure that the rights of medication are being followed. The new checklist also covers corrective actions ,reporting errors and notifying physician, ,resident and pharmacy for errors. The administrator/designee will continue weekly monitoring until 7/31/2026 then

187a Medication Record (continued)

monthly until December 2026. Beginning 2027 the administrator/ designee will do quarterly audits .

Licensee's Proposed Overall Completion Date: *06/30/2026*

Not Implemented [redacted] - 07/22/2026)

225c - Additional Assessment

32. Requirements

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

Description of Violation

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

Plan of Correction ***Accept [redacted] - 06/29/2026)***

The administrator/designee will conduct monthly audits from June 2026 until December 2026 (see audit sheet). Starting 2027 the administrator/designee will conduct quarterly audits and keep records in the administrators files.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented [redacted] - 07/22/2026)