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

March 23, 2026

[redacted] , REGIONAL
WG CENTER CITY SH LLC
[redacted]

RE: ATRIA CENTER CITY
150 NORTH 20TH STREET
PHILADELPHIA, PA, 19103
LICENSE/COC#: 13657

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/28/2026, 01/29/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ATRIA CENTER CITY* **License #**: *13657* **License Expiration**: *10/28/2026*

Address: *150 NORTH 20TH STREET, PHILADELPHIA, PA 19103*

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

Administrator

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

Legal Entity

Name: *WG CENTER CITY SH LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/12/2024* **Issued By**: *Phila L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *200* **Waking Staff**: *150*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *01/29/2026*

Inspection Dates and Department Representative

01/28/2026 - On-Site: [redacted]

01/29/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *165* **Residents Served**: *148*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Guidance* **Capacity**: *25* **Residents Served**: *23*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *148*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *52* **Have Physical Disability**: *0*

Inspections / Reviews

01/28/2026 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/23/2026*

Inspections / Reviews *(continued)*

03/10/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/23/2026*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/20/2026*

03/23/2026 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/20/2026*

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

82c - Locking Poisonous Materials

1. Requirements

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

Description of Violation

On 1/28/2026 at 10:04 am, a deodorant stick and toothpaste tube, with manufacturers' labels indicating "If ingested, contact a medical professional or Poison Control Center" were unlocked, unattended, and accessible in resident #1's medicine cabinet. The door to the room was unlocked. Not all the residents of the home, including resident #1, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

On 1/28/2026, the deodorant stick and toothpaste tube labeled by the manufacturer with the warning, "If ingested, contact a medical professional or Poison Control Center," were immediately secured in Resident #1's locked medicine cabinet by the Life Guidance Director (LGD).

On 1/28/26, the Executive Director (ED) provided re-education to the LGD regarding Chapter 2600.82(c), including the requirement to properly secure poisonous inaccessible to residents.

On 1/28/2026, all Life Guidance staff received re-education regarding Chapter 2600.82(c), including the requirement to properly secure poisonous inaccessible to residents.

On 1/28/2026, the LGD and ED conducted a safety walk of all Life Guidance resident apartments to verify that poisonous materials were properly secured and inaccessible to residents. No additional concerns were identified.

On 1/29/2026 and through the end of the year, the LGD or designee will conduct a daily audit (room checks) of all life guidance resident apartments to ensure all poisonous materials are properly secured and inaccessible to residents.

On 2/19/2026, the LGD sent a written communication to all Life Guidance families regarding poisonous and potentially hazardous materials and the importance of ensuring such items are properly secured.

Beginning 3/2/2026 and continuing monthly thereafter, the ED will conduct random safety audits (room checks) of resident apartments to ensure all poisonous materials are properly secured and inaccessible to residents. Any identified concerns will be addressed immediately and documented.

On 2/26/2026, the ED will conduct an Employee Town Hall meeting to review Chapter 2600.82(c), including the requirement to properly secure poisonous and potentially hazardous materials bearing a manufacturer's warning label stating, "If ingested, contact a medical professional or Poison Control Center."

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

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

82c - Locking Poisonous Materials *(continued)*

Implemented ([redacted] - 03/23/2026)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

On 1/28/2026 at about 9:45 am, the rear hallway leading to the dumpster area was scattered with loose trash, full black trash bags, cardboard boxes, and discarded medical equipment. Several of the large green trash bins in the dumpster area did not have lids and several had lids that were not closed.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

Due to a delayed garbage pickup by Waste Management following Storm Fern, on 1/28/2026 the rear hallway leading to the dumpster area was observed to have loose trash, full trash bags, cardboard boxes, and discarded medical equipment present. Additionally, several large green trash bins in the dumpster area were noted to be without lids or with lids not fully closed. The area was immediately cleaned and organized by the maintenance team on 1/28/2026.

On 1/28/26 and 1/29/26, the ED and Maintenance Director (MD) verified that the rear hallway leading to the dumpster area was clear and free of garbage with the trash cans closed fully with lids.

Beginning on 2/3/26 and continuing twice a day for 90 days, the MD or designee will ensure the rear hallway leading to the dumpster area is free of trash and sanitary conditions are maintained.

On 2/26/26 the ED will hold an Employee Townhall meeting to review the importance of Chapter 2600.85a, especially as it relates to the rear hallway and trash area.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

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

Implemented ([redacted] - 03/23/2026)

89a - Water Pressure

3. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 01/28/26 at 10:50am, the hot water temperature in the shower of residents #2 and #3, measured 69 degrees Fahrenheit preventing the residents from showering.

89a - Water Pressure *(continued)*

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

On 1/28/26, our approved vendor was immediately contacted via phone by the MD regarding the hot water temperature in resident #2 and resident #3 apartment reaching 69 degrees.

From 1/28/2026 through 1/31/2026, residents, including Resident #2 and Resident #3, were offered the option by the Wellness Team and the Resident Services Director (RSD) to shower in vacant apartments where hot water had been verified.

On 1/29/26, our approved vendor came to the community to address various items in the boiler room which resulted in the hot water not reaching temperature. Multiple proposals were sent to the community on 1/29/26 which were immediately approved by Atria Senior Living.

On 1/31/2026, the MD and ED confirmed that all necessary repairs and replacements in the boiler room were completed by the vendor, including replacement of the bearing assembly and the hot water circulation pump. Following completion of the repairs, hot water was tested in the apartments of Resident #2 and Resident #3, with no additional concerns identified.

Beginning 2/6/26 and weekly for 90-days, the MD or designee will audit 3 random resident apartments to ensure their hot water in the apartment is in compliance. Any identified concerns will be addressed immediately and documented.

On 2/18/2026, the ED interviewed Resident #2 and Resident #3 to confirm that hot water was hot enough to shower. Both residents reported no concerns, and they have had hot showers.

On 2/26/26 the ED will hold an Employee Townhall meeting to review the importance of Chapter 2600.89a especially as it related to water temperature in resident apartments including the shower.

On 2/25/2026, the MD will advise residents at the monthly Resident Council meeting to review the importance of hot water in apartments, particularly in showers, and to emphasize that all equipment in resident apartments, including HVAC systems, should be in working order. The MD will review the work order system and the importance of reporting any concerns in resident apartments regarding hot water and working equipment so the maintenance team can address them promptly.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

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

Implemented ([redacted] - 03/23/2026)

91 - Telephone Numbers

4. Requirements

2600.

91 - Telephone Numbers *(continued)*

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 1/28/2026 at 10:18 am, there were no emergency telephone numbers to include the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline, on or by the telephone near the Life Guidance kitchen.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

On 1/28/26, emergency telephone numbers including the nearest hospital, police department, fire department, ambulance, poison control, local emergency management, and the personal care home complaint hotline were immediately posted near the telephone located by the Life Guidance kitchen.

On 2/3/26 through 2/6/26, the ED conducted a building walk through and all resident apartments to ensure that emergency telephone numbers including the nearest hospital, police department, fire department, ambulance, poison control, local emergency management, and the personal care home complaint hotline were posted near a telephone that has an outside line. No additional concerns identified.

On 2/25/2026, the ED or designee will advise residents at the monthly Resident Council meeting the importance of having emergency telephone numbers including the nearest hospital, police department, fire department, ambulance, poison control, local emergency management, and the personal care home complaint hotline by their telephone that has an outside line. These numbers will be handed out and given to residents during this meeting.

On 2/26/26 the ED will hold an Employee Townhall meeting to review the importance of emergency telephone numbers including the nearest hospital, police department, fire department, ambulance, poison control, local emergency management, and the personal care home complaint hotline were immediately posted near the telephone mentioned in Chapter 2600.91.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

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

Implemented ([redacted] - 03/23/2026)

95 - Furniture and Equipment

5. Requirements

2600.

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

Description of Violation

On 1/28/2026 at 9:57 am, a water heater in the basement was leaking, leaving a large puddle of water on the floor.

At 10:50 am, the heater in resident room [redacted] reached was not operating correctly.

95 - Furniture and Equipment *(continued)*

Plan of Correction ***Accept (- 03/10/2026)***

On 1/28/26, our approved vendor was immediately contacted via phone by the MD regarding the water heater in the basement that was leaking which left a large puddle of water on the floor.

On 1/28/26, our approved vendor was immediately contacted via phone by the MD regarding the heater in resident room

On 1/29/26, our approved vendor came to the community to address various items in the boiler room including the water heater leak. Multiple proposals were sent to the community on 1/29/26 which were immediately approved by Atria Senior Living.

On 1/31/2026, the MD and ED confirmed that all necessary repairs and replacements in the boiler room were completed by the vendor, including replacement of the bearing assembly and the hot water circulation pump. Following completion of the repairs, the hot water heater was no longer leaking and there was no water on the floor in the basement.

On 1/31/26, the repairs to resident room were completed with no further concerns by both residents.

Beginning 2/6/26 and weekly for 90-days, the MD or designee will check the water heater to ensure it is in good repair, clean and free of hazards including water on the floor.

Beginning 2/6/26 and weekly for 90-days, the MD or designee will audit 3 random resident apartments to ensure their HVAC is in working order with no issues. Any identified concerns will be addressed immediately and documented.

On 2/26/26 the ED will hold an Employee Townhall meeting to review the importance of Chapter 2600.89a especially as it related to water temperature in resident apartments including the shower.

On 2/25/2026, the MD will advise residents at the monthly Resident Council meeting to review the importance of hot water in apartments, particularly in showers, and to emphasize that all equipment in resident apartments, including HVAC systems, should be in working order. The MD will review the work order system and the importance of reporting any concerns in resident apartments regarding hot water and working equipment so the maintenance team can address them promptly.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

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

Implemented (- 03/23/2026)

101j7 - Lighting/Operable Lamp

6. Requirements

101j7 - Lighting/Operable Lamp *(continued)*

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

On 1/28/2026 at resident #4 did not have access to a source of light that could be turned on/off at bedside. The room itself was only dimly lit.

Repeat violation Date: 1/30/25 et al.

Plan of Correction ***Accept (- 03/10/2026)***

On 1/28/26, the MD immediately installed push lights that can be turned off/on at bedside for Resident #4.

On 2/5/26 with a completion date of 2/9/26, the ED and MD completed an audit of all resident apartments to ensure there is an operable lamp or other source of lighting that can be turned off/on at bedside.

On 2/13/26, the ED or designee will conduct random weekly checks of 3 random resident rooms including new move ins to verify there is an operable lamp or other source of lighting that can be turned off/on at bedside for 90 days. When a new resident moves in the ED or designee will confirm that there is an operable lamp or other source of lighting that can be turned off/on at bedside. No new move ins scheduled at this time.

On 2/26/26 the ED will hold an Employee Townhall meeting to review the importance of Chapter 2600.101j7.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to the violation does not occur.

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

Implemented (- 03/23/2026)

103f - Refrigerator/Freezer Temps

7. 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 1/28/2026 at 10:18 am, the temperature in the Life Guidance kitchen refrigerator was 44 degrees Fahrenheit and on 1/29/26 at 9:56 am it was still 44 degrees Fahrenheit.

Repeat violation date: 1/30/25 et al.

Plan of Correction ***Accept (- 03/10/2026)***

On 1/29/25, the MD immediately contacted our third-party vendor via phone to service the Life Guidance kitchen refrigerator which was at 44 degrees Fahrenheit on 1/28 and 1/29.

On 1/28/26 and 1/29/26, the LGD relocated all perishable foods from the Life Guidance kitchen refrigerator.

103f - Refrigerator/Freezer Temps (continued)

Beginning 2/3/26 and daily for 90 days, the LGD or designee will conduct daily temperature checks to ensure the Life Guidance kitchen refrigerator is below 40 degrees Fahrenheit.

On 2/2/26, the third-party refrigeration vendor came on site to service the Life Guidance kitchen refrigerator and concluded the fridge control board needed to be reset.

On 2/2/26, the fridge control board was reset with no additional concerns, and the temperature remains under 40 degrees.

On 2/26/26 the ED will hold an Employee Townhall meeting to review the importance of Chapter 2600.103f.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

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

Implemented ([redacted] - 03/23/2026)

121a - Unobstructed Egress

8. 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 1/28/2026 at 9:29am, a pile of icy snow blocked egress from the home's South stairway. The door could only be pushed open with great force. Additionally, the door behind the kitchen leading to the dumpster area was locked. this door is marked as an emergency exit.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

On 1/28/26, the pile of icy snow that was blocking egress from the south stairway was immediately cleared.

On 1/29/26, MD installed a push-button release on the door located behind the kitchen to ensure it functions as an accessible emergency exit when needed.

Beginning 2/3/26 and continuing twice a day for 90 days, the MD or designee will conduct a building walkthrough, including the exterior of the building, to ensure that all stairways, hallways, doorways, passageways, and egress routes from resident rooms and from the building are unlocked, accessible, and free from obstruction.

On 2/26/26, ED will conduct an Employee Town Hall meeting to review the requirements of Chapter 2600.121(a), with specific emphasis on maintaining clear and accessible egress at the door located behind the kitchen.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

121a - Unobstructed Egress *(continued)*

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

Implemented ([redacted] - 03/23/2026)

182b - Prescription Medication

9. Requirements

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

Description of Violation

On 1/12/2025 at 9:00 pm, staff person A administered medications to residents, including a 500-mg Levetiraceta tablet to resident #5. Staff person A did not complete medication training with a qualified trainer.

On 1/23/25 at 9:00 am, staff person B administered medications to residents, including a tablespoonful of Lactulose solution to resident #5. Staff person B did not complete medication training with a qualified trainer.

Repeat Violation date: 5/28/25

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

On 1/28/26, Staff Person A was immediately removed from the medication cart and all medication-related assignments due to not having completed medication administration training by a qualified trainer.

On 1/28/26, Staff Person B was immediately removed from the medication cart and all medication-related assignments due to not having completed medication administration training by a qualified trainer.

On 1/28/26, all Certified Medication Technicians in the community were immediately removed from the medication cart and all medication administration assignments due to not having completed medication administration training by a qualified trainer. The RSD, RSS, and Wellness Nurses assumed responsibility for medication administration in their place to ensure continued compliance and resident safety.

On 1/30/2026, the ED conducted an in-service with the CBD, RSD, and RSS regarding the requirements of 55 Pa. Code Chapter 2600.182(b) and the importance of ensuring that any staff person administering medications has successfully completed the medication administration training specified in 55 Pa. Code 2600.190. The training requirement includes administration of oral, topical, eye, nose, and ear drop prescription medications, as well as insulin injections and epinephrine injections for insect bites or other allergic reactions.

On 1/28/26, the RSD reached out to [redacted] who has been recognized by the PA DHS as a trainer to teach the DHS Medication Administration Course.

On 1/29/26, [redacted] confirmed [redacted] would be in the community on 2/1/26 to complete the DHS Medication Administration training as the qualified trainer.

From 2/1/26 through 2/3/26, [redacted], a qualified medication administration trainer, provided and completed medication administration training for all staff persons responsible for administering medications.

On 2/19/26 and 2/20/26, the RSD and RSS conducted a staff meeting with all Wellness staff, including all staff

182b - Prescription Medication (continued)

persons who administer medications, to review and reinforce the importance of completing required medication administration training.

On 2/3/2026, the CBD and RSD conducted an audit of all direct care certified staff who administer medications to verify successful completion of the medication administration training as specified in 55 Pa. Code 2600.190 (relating to medication administration training). This includes training for the administration of oral, topical, eye, nose, and ear drop prescription medications, as well as insulin injections and epinephrine injections for insect bites or other allergic reactions. No additional concerns were identified.

Beginning 2/9/26, the CBD and RSD will conduct a weekly audit for 90 days following the hire date of the first new direct care employee to verify that all direct care certified staff who administer medications have successfully completed the medication administration training as specified in 55 Pa. Code 2600.190 (relating to medication administration training). This includes training for the administration of oral, topical, eye, nose, and ear drop prescription medications, as well as insulin injections and epinephrine injections for insect bites or other allergic reactions.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

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

Implemented ([redacted] - 03/23/2026)

183b - Meds and Syringes Locked

10. Requirements

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

Description of Violation

On 1/28/2026 at 9:30 am, Diclofenac Sodium cream and Flonase nasal spray were unlocked, unattended, and accessible in room [redacted]. Resident #4's medical evaluation, dated 10/30/25, states that the resident cannot self-administer medications.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

On 1/28/26, the RSD immediately removed the Diclofenac Sodium cream and Flonase nasal spray from Resident #4's apartment after identifying that the medications were unsecured. Resident #4 is not assessed as capable of self-administering or self-managing medications

On 1/29/26, the RSD provided education to Resident #4 regarding medication safety and Resident #4 was informed that [redacted] may not keep prescription medications, OTC medications, CAM, or syringes in [redacted] apartment, as [redacted] has not been assessed as capable of self-administering or self-managing [redacted] medications. No additional concerns noted at the time of the conversation and resident expressed understanding.

On 2/3/26, the RSD and RSS conducted an audit to verify that residents on the medication administration program did not have prescription medications, over-the-counter (OTC) medications, complementary and alternative

183b - Meds and Syringes Locked (continued)

medications (CAM), or syringes stored in their apartments. No additional concerns identified.

On 2/17/26, The Regional Care Director completed
training to the ED, RSD and RSS on the importance of the requirements of Chapter 2600.183b emphasizing the importance of ensuring that residents enrolled in the medication program do not store prescription medications, OTC medications, CAM, or syringes in their apartments.

On 2/19/26, the RSD and RSS completed an in-service
for all Wellness Nurses, Resident Services Assistants and Resident Medication Assistants, the importance of the requirements of Chapter 2600.183b emphasizing the importance of ensuring that residents enrolled in the medication program do not store prescription medications, OTC medications, CAM, or syringes in their apartments.

Starting 2/23/26, RSD and RSS will audit 5 random residents weekly for 90-days who are on the medication program to ensure they do not have any prescription medications, OTC medications, CAM, or syringes in their apartments.

By 2/28/26, the RSD will send out resident and family communication emphasizing the importance of ensuring that residents enrolled in the medication program do not store prescription medications, OTC medications, CAM, or syringes in their apartments.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

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

Implemented ([redacted] - 03/23/2026)

185a - Implement Storage Procedures

11. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 1/26/2026 at 9:00 pm, resident #6 had a blood sugar reading of 258. However, the reading was logged as 254 in the resident's medication administration record.

On 1/28/26 at 9:30 am, there were thirteen oxygen tanks were unsecured and accessible, lined up against a the wall in room 101.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

On 1/28/26, the RSS immediately secured the 13 oxygen tanks that were lined up against the wall in room 101.

On 1/28/26, the RSS conducted an audit of all resident apartments in which oxygen was in use to ensure oxygen equipment was properly secured and accessible. No additional concerns were identified.

185a - Implement Storage Procedures (continued)

On 1/29/26, the RSD and RSS immediately in-serviced the Wellness Nurse that logged the incorrect reading from the glucometer to the resident's medication record on 1/26/26 at 9:00pm.

On 2/17/26, The Regional Care Director completed
training to the Executive Director and Resident Service Director and Resident Services Supervisor on the requirements of 2600.185(a), emphasizing accurate and complete documentation when transcribing blood glucose readings from the glucometer to the resident MAR.

On 2/19/26, the RSD and RSS conducted an in-service for all Wellness Nurses, Resident Services Assistants, and Resident Medication Assistants on the requirements of 2600.185(a), with emphasis on residents using oxygen, ensuring that oxygen tanks are properly secured and accessible.

On 2/19/26, the RSD and RSS conducted an in-service for all Wellness Nurses on the requirements of 2600.185(a), emphasizing accurate and complete documentation when transcribing blood glucose readings from the glucometer to the resident MAR.

Starting 2/23/26, the RSD and RSS will conduct weekly audits of glucometer readings, comparing each result to the corresponding MAR documentation for all residents who require blood glucose monitoring, for 90 days.

Starting 2/23/26, the RSD or designee will conduct a weekly audit for 90 days in each apartment where residents require oxygen to ensure that oxygen tanks are properly secured and readily accessible.

On 2/26/26 the ED will hold an Employee Townhall meeting to review the importance of 2600.185(a), with emphasis on residents using oxygen, ensuring that oxygen tanks are properly secured and accessible.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

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

Implemented ([redacted] - 03/23/2026)

187a - Medication Record

12. 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.

187a - Medication Record *(continued)*

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 #5 is prescribed insulin injections four times a day, after each meal and at bedtime. However, the resident's medication administration record for January 2026 erroneously indicated only three administrations per day.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

On 1/29/26, The medication order for the insulin injections for Resident #5 was discontinued and entered in the system to reflect the medication administration record correctly as per prescribers' orders.

On 2/3/26, RSD and RSS completed an audit to ensure all medication records for each resident included all requirements mentioned in Chapter 2600.187a especially frequency of administration.

On 2/17/26, The Regional Care Director completed training to the Executive Director and Resident Service Director and Resident Services Supervisor on Management of Medication administration record using an electronic medication administration record (work instruction MED-003-01).

On 2/19/26, the RSD and RSS completed an in-service for all Wellness Nurses on the importance of the requirements of Chapter 2600.187a as it relates to
Management of Medication administration record using an electronic medication administration record (work instruction MED-003-01).

Starting 2/23/26, RSD and RSS will monitor the Triple Checks weekly for 90 days to ensure all medication administration records meet the requirements of Chapter 2600.187a.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

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

Implemented ([redacted] - 03/23/2026)

225c - Additional Assessment

13. 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 4's assessment, dated [redacted], does not include the resident's need for or use of bedside mobility devices.

225c - Additional Assessment (continued)

The resident is using two beside mobility devices attached to their bed on 1/28/26.

Plan of Correction ***Accept ([redacted] - 03/10/2026)***

On 1/29/26, a new assessment was completed for Resident #4 to include the residents' need for two bedside mobility devices.

On 1/30/26, an audit of all residents who have a bedside mobility device was completed by the RSD and RSS and verified by the ED that their beside mobility device was documented in their assessment. No additional concerns identified.

Starting 2/23/26, the RSD or designee will conduct a weekly audit for 90 days to ensure that all residents who use a bedside mobility device have this documented in their assessment.

On 2/26/26, the ED will hold an Employee Townhall meeting to review the requirements of Chapter 2600.225(c), emphasizing the importance of ensuring that all residents who use a bedside mobility device have this documented in their assessment.

By 2/28/26, the ED, RSD, and RSS will conduct a full-building apartment walk-through to verify that all residents who use a bedside mobility device have this documented in their assessments.

By 2/28/26, the RSD will send out resident and family communication emphasizing the importance of ensuring that all residents who use a bedside mobility device have this documented in their assessment.

On 3/30/26 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

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

Implemented ([redacted] - 03/23/2026)