

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

April 20, 2026

[REDACTED], MANAGER
TWINING RETIREMENT COMMUNITY LLC
[REDACTED]

RE: HOLLAND SENIOR LIVING
COMMUNITY
1400 OLD JORDAN ROAD
HOLLAND, PA, 18966
LICENSE/COC#: 14657

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: *HOLLAND SENIOR LIVING COMMUNITY* License #: *14657* License Expiration: *08/30/2026*
 Address: *1400 OLD JORDAN ROAD, HOLLAND, PA 18966*
 County: *BUCKS* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *TWINING RETIREMENT COMMUNITY LLC*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *Other* Date: *03/13/1989* Issued By: *CWOPA - L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *97* Waking Staff: *73*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal, 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: *152* Residents Served: *59*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Memory Care unit* Capacity: *27* Residents Served: *13*

Hospice
 Current Residents: *9*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *59*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *38* Have Physical Disability: *3*

Inspections / Reviews

01/28/2026 Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/08/2026*

03/16/2026 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *04/20/2026*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/21/2026*

Inspections / Reviews *(continued)*

04/03/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/20/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/13/2026

04/14/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/20/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/20/2026

04/20/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/20/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

44g - Telephone Number

1. Requirements

2600.

44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone number of the complaint hotline for the personal care home is not posted in a conspicuous and public place in the home.

Plan of Correction

Accept ([redacted]) - 04/03/2026

I kindly ask for an explanation of this violation so I can ensure the proper information is listed. It's difficult to provide a sustaining plan if I am not given the information.

Action: The secondary list of phone numbers was added to the board as attached.

Sustain: Now that I have been told this exact sheet must remain visible, I will ensure it remains under the case. This has been listed in Memory Care, the front lobby, as well as on the bulletin board for the residents and families. It is also listed in the contract. The administrator will check at least bi-annually to ensure the numbers are posted.

Proposed Overall Completion Date: 03/17/2026

Licensee's Proposed Overall Completion Date: 03/17/2026

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

64c - Annual Training

2. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

[redacted] the home's administrator, completed only 15 hours of Department-approved training in the training year 2025.

Plan of Correction

Accept ([redacted]) - 04/03/2026

The administrator has signed up for numerous trainings approved by the Department and will compare them to the list of required training in regulations 2600.64c.

- * Managing Challenging Behaviors on March 19th.
- Resident Elopement will be presented at the April 21st session.
- Gas Leak with Fire and Evacuation will be presented at the May 19th session.
- * Hospice & Palliative Care in the Personal Care Home on March 30th.
- * Effective Complaint Procedure Management on April 23rd.

Plan: The administrator will use the guide emailed from the surveyor to accomplish the needed training.

64c Annual Training (continued)

Monitoring: The administrator will review the Department approved training at least bi annually, to ensure they have completed 24 hours of administrative training annually.

Proposed Overall Completion Date: 03/19/2026

Licensee's Proposed Overall Completion Date: 03/19/2026

Implemented (█) - 04/14/2026)

65f - Training Topics**3. 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

Staff person B did not receive training in medication self administration training and safe management techniques during training year 2025.

Staff person C did not receive training in safe management techniques during training year 2025.

Plan of Correction

Directed (█) - 04/03/2026)

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.65f. I will need assistance with Safe Management Techniques. I understand it to be such training as De Escalation, Hygiene, and Fall Prevention. If this is incorrect, please guide me. I have talked with other administrators, and I am getting this information. However, this training was already complete.

Issue: Staff member B did not receive training in medication self administration and safe management techniques during training year 2025.

Staff person C did not receive training in safe management techniques during the training year 2025.

Action: Staff Member B had training for Medication Self Administration, on 4/1/26, by the Administrator. See attached.

Plan: All staff will receive medication Self Administration training by 3/30/26.

Sustain: Both training courses have been added to the annual training topics as attached. The administrator will ensure the staff has training based on the training plan that was revised at least bi annually, starting immediately..

65f - Training Topics (continued)*Proposed Overall Completion Date: 03/30/2026**Directed Completion Date: 03/30/2026**Implemented (█) - 04/14/2026)***65g - Annual Training Content****4. 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 fire safety and falls and accident prevention during training year 2025.**Staff person D did not receive training in falls and accident prevention during training year 2025.**Staff person E did not receive training during training year 2025 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.

Plan of Correction*Accept (█) - 03/16/2026)**Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.65g**Issue: Staff Member C did not receive fire safety training, but did receive training in falls and accident prevention. See 65f attachment. Staff Member D did not receive training in falls and accident prevention. Staff member no longer employed. Staff member E did not receive the training in multiple areas as an ancillary staff member.**Action: Administrator provided training in all missing areas to Staff Members C and E as attached.**Plan: Administrator to have Directors of ancillary staff members pull training records and provide updated training for staff by 3/30/26**The administrator will work with the Director of Human Resources and the Directors of Culinary and Housekeeping to ensure staff members are receiving the same training provided to the nursing staff.**Sustain: Administrator and Directors of Housekeeping and Culinary will meet on a monthly basis to ensure the*

65g Annual Training Content (continued)

training will continue to satisfy the required hours of annually as stated in regulation 2600.65g See attached.

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

Implemented () - 04/14/2026

82c - Locking Poisonous Materials

5. 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, in room 2209, there was Colgate toothpaste, a bar of soap, Listerine mouthwash, and Nature's Promise laundry detergent with a manufacturer's label indicating "Please keep out of the reach of children. If swallowed, please contact the poison control center immediately." It was unlocked, unattended, and accessible to residents in room 2209. Not all the residents of the home, including the resident in room 2209, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction

Accept () - 03/16/2026

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.82c

Issue: Apartment in secured unit had what would be considered poisonous material unlocked and not out of reach of other residents.

Action: Supplies were immediately placed in the locked cabinet located in the apartment.

Plan: In service initiated by the Administrator with all memory care neighborhood staff members to ensure awareness of why the items need to be locked away. See attached. Will complete all inservice by 3/11/26

Sustain: Memory Care Coordinator and Clinical Service Manager will provide a weekly check of all occupied apartments. Report any issues with the locked cabinets. This documentation will be provided daily to the Administrator. Administrator will perform random audits weekly x4, then bi weekly x4 weeks and then monthly x4 as attached.

Licensee's Proposed Overall Completion Date: 03/11/2026

Implemented () - 04/14/2026

96a - First Aid Kit

6. Requirements

2600.

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

Description of Violation

The first aid kit in the kitchen does not include a thermometer, scissors, and tweezers.

96a - First Aid Kit (continued)

Plan of Correction

Accept (█) - 03/16/2026

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.96a

Issue: The first aid kit in the kitchen was missing items.

Action: Administrator corrected immediately on site, adding the thermometer, scissors, and tweezers.

Plan: In-service initiated by the Administrator with ancillary staff to include the importance of keeping the first aid kit replenished. If an item is used, the culinary manager must be informed so the first aid kit can be replenished. Will be completed by 3/16/26. See attached.

Sustain: Weekly audits will start 3/16/26 and will continue x 4 weeks, then monthly x 3 months by the Administrator.

Licensee's Proposed Overall Completion Date: 03/16/2026

Implemented (█) - 04/14/2026

121a - Unobstructed Egress

7. 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 0/28/2026, on the 2nd floor, East stair E, there was a chair blocking the egress from the home.

Plan of Correction

Accept (█) - 03/16/2026

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.121a.

Issue: A chair outside the building's exit door of the kitchen was blocking the exit.

Action: The chair was immediately removed from the area and placed back in the dining room.

Plan: In-service initiated by the administrator will provide education to the staff members regarding the importance of keeping a clear exit. This will be completed by 3/21/26.

Sustain: Weekly audits throughout the building by maintenance or designee for 4 weeks, then bi-weekly for 4 weeks, then monthly for 4 months. See attached.

Licensee's Proposed Overall Completion Date: 03/21/2026

Implemented (█) - 04/14/2026

162c - Menus Posted

8. Requirements

2600.

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

Description of Violation

The home's menu for the week of 01/18/2026 and 01/26/2026 was posted. However, the menu stating the specific food being served at each meal for 1 week in advance was not posted in a conspicuous and public place in the home.

Plan of Correction

Accept (█) - 03/16/2026

Our POC will be prepared and executed to improve the quality of care continually and to comply with all

162c - Menus Posted (continued)

applicable state and federal regulatory requirements under 2600.162c

Issue: The menu was not posted for the week of 2/1/26.

Action: The menu was placed the same day, prior to the administrator being aware of the fact that the surveyor had noted it. We had a major snow and ice storm, which changed our priorities for the week.

Plan: In-service initiated with the culinary team and the administrative secretary. The administrator provided education on the regulation for the importance of displaying the menu both current and advance week. To be completed by 3/10/26 See attached.

Sustain: Weekly audits by Administrator or designee for 4 weeks, then biweekly for 4 weeks, then monthly for 4 months. See attached.

Licensee's Proposed Overall Completion Date: 03/10/2026

Implemented () - 04/14/2026

171b5 - First Aid Kit

9. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the van that is used to transport residents does not include a thermometer.

Plan of Correction

Accept () - 03/16/2026

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.171b5

Issue: The first aid kit in the vehicle was missing a thermometer.

Action: Administrator corrected immediately on site, adding the thermometer.

Plan: In-service initiated by the Administrator with the drivers and Director of transportation to include the importance of keeping the first aid kit replenished. If an item is used, the Director of transportation must be informed so the first aid kit can be replenished. Will be completed by 3/16/26. See attached.

Sustain: Weekly audits will start 3/16/26 and will continue x 4 weeks, then monthly x3 by the Administrator.

Licensee's Proposed Overall Completion Date: 03/16/2026

Implemented () - 04/14/2026

181d - Storing Medication

10. 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

The resident in room self-administers medications and stores medications in room. On 01/28/2026, there were several unlocked, unattended medications in the resident's bedroom.

181d Storing Medication (continued)

Plan of Correction

Accept () - 03/16/2026

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.181d

Issue: Resident's room was left unlocked and therefore open to have medications taken from apartment.

Action: The resident was immediately informed that must keep door locked when is not in the apartment.

Plan: In service initiated with the nursing staff on the regulations stating that medications need to be stored in a locked area. Education provided by the administrator is attached. Will be completed by 3/12/26.

Sustain: Weekly audits will start 3/16/26 and will continue x 4 weeks, then monthly x4 by the Administrator.

Licensee's Proposed Overall Completion Date: 03/12/2026

Implemented () - 04/14/2026

182c - Medication Administration

11. Requirements

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On 1/28/2026 at 9:30 a.m., during a medication pass to resident 1, staff member F left the medications in a small cup for the resident to administer at a later time and walked away from the resident's room. The home did not observe if the resident refused or swallowed the medications.

Plan of Correction

Accept () - 03/16/2026

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.182c.

Issue: Resident was left unattended with medication and did not observe the administration of medication.

Action: In service initiated by Clinical Service Manager with med technicians on the importance of the accuracy of documentation, which includes witnessing the completion of a med pass.

Plan: Ongoing training will continue with med techs to be completed by 3/18/26

Sustain: Weekly audits will start 3/23/26 and will continue for x 4 weeks, then randomly by the Administrator.

Licensee's Proposed Overall Completion Date: 03/18/2026

Implemented () - 04/14/2026

187b - Date/Time of Medication Admin.

12. 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

Various residents, including residents 1 and 2, have prescribed medications that were administered, and the medication record does not include the initials of the staff person who administered them.

Resident 1 is prescribed for vital signs readings everyday. Resident 1 medication administration record does not include the initials of the staff person who complete the vital signs on 1/17/2026.

Resident 2 is prescribed Levothyroxide sodium oral tablet. Resident 2's medication administration record does not include the initials of the staff person who administered on 1/01/2026 at 6:00 a.m.

Resident 2 is prescribed Lorazepam oral concentrate 2 mg. Resident 2's medication administration record does not include the initials of the staff person who administered on 1/04/2026 and 1/10/2026 at 20:00 p.m.

Plan of Correction

Accept (█ - 03/16/2026)

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.187b

Issue: Medications are not being signed out of the EMAR system.

Action: In-service initiated by the Clinical Service Manager to the med techs, educating the team members regarding the proper sign-off procedures. Education is also provided to the charge nurses by showing the system's outstanding medications at the end of each shift. This will be completed by 3/23/26.

Sustain: Administrator will provide weekly audits, randomly choosing a unit to evaluate. This will be conducted weekly x4 weeks, then bi-weekly x4 weeks.

Licensee's Proposed Overall Completion Date: 03/23/2026

Implemented (█ - 04/14/2026)

187d - Follow Prescriber's Orders

13. Requirements

2600.

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

Description of Violation

Resident 2 is prescribed Lorazepam oral concentrate 2 mg. However, the medication was not administered on 01/03/2026 and 1/21/2026 according with the medication administration record and the controlled substances record.

Plan of Correction

Accept (█ - 03/16/2026)

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.187d

Issue: The EMAR was left blank instead of signing out that the medication was refused, or what action was taken.

187d - Follow Prescriber's Orders (continued)

Action: In-service initiated by the administrator to educate the med techs on signing out the medication or noting a reason why it was not given. In this instance, it is given by the charge nurses who were also started education and will be completed by 3/10/26.

Plan: The Clinical Service manager or charge nurse will run a report before the end of each shift to check on the outstanding open tasks in PointClickCare.

Sustain: A weekly audit x 4 will be performed by the administrator or designee on various units to ensure accuracy.

Licensee's Proposed Overall Completion Date: 03/10/2026

Implemented (█) - 04/14/2026)

224a - Preadmission Screen Form**14. Requirements**

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 3's preadmission screening form, dated █, includes a determination that the needs of the resident can not be met by the services provided by the home.

Plan of Correction

Accept (█) - 03/16/2026)

Our POC is prepared and executed as a means to continually improve the quality of care and to comply with all applicable state and federal regulatory requirements for 2600.224a

Issue: Resident 3 prescreen stated the home could not meet the needs of the resident.

Action: The prescreen was immediately updated and initialed due to the clerical error. See attached.

Plan: In-service completed by administrator with the Clinical Service Manager regarding proper completion of the prescreening process. See attached.

All memory care prescreens have been reviewed by the administrator for accuracy. Balance of Personal Care residents' prescreen will be reviewed by the Clinical Service Manager by 3/20/26

Sustain: Administrator or designee will review all required documents on the day of admission and biannually in order to assure on-going compliance.

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

Implemented (█) - 04/14/2026)

225c - Additional Assessment**15. 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 was completed on █ however, the resident's assessment plan does not include that

225c Additional Assessment (continued)

the need for a hospital bed with a half rail attached.

Plan of Correction

Accept () - 03/16/2026)

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.225c

Issue: Assessment plan of resident 4 did not state a need for a half rail.

Action: Inservice initiated by the Administrator to educate the nursing staff on the importance of informing the staff if a rail is added to the bed. We currently tell all residents that they are not permitted without an order and therapy. A check of all of the apartments will be completed by the administrator for bed rails/enablers by 3/9/26, and in service will be completed by 3/16/26.

Plan: The Clinical Service Manager is updating a monthly audit sheet that is signed off by the nursing staff, which will now include bed rails.

Sustain: The monthly audit form will serve as the guide and random checks will be performed every 2 weeks x 8 weeks to one unit by the administrator or designee. See attached.

Licensee's Proposed Overall Completion Date: 03/04/2026

Implemented () - 04/14/2026)

234b - Support Plan Needs Elements

16. Requirements

2600.

234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated [redacted], for resident 3 is marked as the resident needing total physical assistance in securing and using transportation, managing finances, and making and keeping appointments, but it doesn't explain the description of service needed. It is also marked that resident 3 needs some physical assistance using the telephone, caring for personal possessions, and obtaining cleanliness and seasonal clothing, but it doesn't explain the description of services needed. Engaging in social and leisure activities is marked as prompting/cueing, but it doesn't specify the description of service need. Short term memory and long term memory are marked as moderate problems, but it doesn't specify the description of services needed.

Plan of Correction

Accept () - 03/16/2026)

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.234b

Issue: The RASP Care Plan did not reflect how the home would assist with the resident's needs.

Action: In service by the administrator was conducted with charge nurses and the memory care coordinator to educate on the importance of a completed care plan. See attached.

Plan: Care Plans will be reviewed by the Clinical Service Manager and Administrator for completion. This will be completed by 3/23/26.

The Clinical Service Manager will review all care plans going forward that are completed by the charge nurses and the memory care coordinator for accuracy and completion.

If a care plan is completed by the Clinical Service Manager, the administrator will review the care plan for accuracy and completion.

Sustain: Monthly audits will be performed by the administrator starting in April 2026 x4 months.

Licensee's Proposed Overall Completion Date: 03/23/2026

234b - Support Plan Needs Elements (continued)

Implemented (████) - 04/20/2026

236 - Staff Training

17. Requirements

2600.

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

Description of Violation

Staff person B, who works in the Secure Dementia Care Unit (SDCU), had only 3.5 hours of training in dementia care during the 2025 training year.

Staff person D, who works in the Secure Dementia Care Unit (SDCU), had only 3 hours of training in dementia care during the 2025 training year.

Plan of Correction

Accept (████) - 03/16/2026

Our POC will be prepared and executed to improve the quality of care continually and to comply with all applicable state and federal regulatory requirements under 2600.236

Issue: Staff member D did not have enough training hours in dementia care. Staff member B had enough hours at 6.5 as attached on 65f.

Plan: This action falls directly on the administrator (me), and I am reaching out to various resources to schedule additional training, all pertaining to dementia. Staff member D is no longer with the company. Training has already started in January 2026 and I have added additional trainings as attached.

Sustain: This plan will be followed up by the administrator or designee on a monthly basis to ensure that the training is PLANNED and COMPLETED to follow the monthly calendar as attached.

Licensee's Proposed Overall Completion Date: 03/04/2026

Implemented (████) - 04/20/2026