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

June 9, 2026

, ADMINISTRATOR
EMERITUS CORPORATION

RE: BROOKDALE GRANDON FARMS
1100 GRANDON WAY
MECHANICSBURG, PA, 17055
LICENSE/COC#: 31612

Dear

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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *BROOKDALE GRANDON FARMS* **License #**: *31612* **License Expiration**: *01/17/2027*

Address: *1100 GRANDON WAY, MECHANICSBURG, PA 17055*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *EMERITUS CORPORATION*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *03/15/2005* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *98* **Waking Staff**: *74*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *02/06/2026*

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: *120* **Residents Served**: *86*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Clare Bridge* **Capacity**: *30* **Residents Served**: *24*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *86*

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

Have Mobility Need: *12* **Have Physical Disability**: *0*

Inspections / Reviews

01/28/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *03/06/2026*

Inspections / Reviews *(continued)*

03/06/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/30/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/13/2026*

03/13/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/30/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/31/2026*

06/09/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/30/2026*

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

16c - Written Incident Report

1. Requirements

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

Description of Violation

On [redacted] PM, Staff Members allegedly hit the side of Resident #1's legs while taunting the resident. This allegation of staff to resident abuse was reported to the Health and Wellness Coordinator at the time of the incident. The home did not report the allegation of abuse to the Department until [redacted]

Repeated Violation - 3/13/25

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

1/30/2026- The Executive Director retrained all appropriate staff on written Incident Report and reporting timely. Ongoing-To assist with compliance, The ED or designee will review any potential incidents as they occur daily for one (1) month Starting on 2/1/2026 through 2/28/2026. Following, reviews by the ED will occur weekly for one (1) additional month to verify compliance starting 3/1/2026 and ending 3/31/2026.
Monthly reviews will be completed thereafter by the Executive Director or designee too verify compliance and to determine if any further action is warranted.

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

Implemented ([redacted] - 06/09/2026)

17 - Record Confidentiality

2. Requirements

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

Description of Violation

On 1/28/26, at 10:51 AM, Resident #2's personal information including skilled interventions for physical therapy and the patient record was unlocked, unattended and accessible in the Therapy room on an unlocked laptop.

On 1/28/26 at 11:30 AM, a resident evacuation list was unlocked, unattended and accessible in the 400-hallway kitchenette. The list included the names of residents along with supervision and assistance needed to evacuate including the needs of Residents #3, #4 and #5.

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

Immediately the Maintenance Director locked the therapy door and removed the resident evacuation list.
1/30/2026- The Executive Director re-trained the management team and therapy team on the community policy regarding confidentiality.

17 Record Confidentiality (continued)

1/30/2026 The Executive Director retrained the appropriate staff on the community policy regarding confidentiality at monthly staff meetings.
Ongoing to assist with compliance, the Health and Wellness Director or designee will conduct weekly audits for two (2) months starting on 2/1/2026 and ending on 3/31/2026 to identify compliance with securing of confidential information.
The Executive Director or Designee will review the audit results to verify if any further action is warranted.

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

Implemented (█ - 06/09/2026)

18 - Compliance With Laws

3. Requirements

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

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 9/23/16, requires the battery of battery operated carbon monoxide alarms be labeled with the date of installation and replaced at least once annually. On 1/28/26 multiple carbon monoxide detectors throughout the home, including in mechanical areas, laundry areas, and common hallways, were labeled "3 19". These labels did not indicate the month, date, and year that the batteries were last changed, and the home was unable to identify what date "3 19" referred to.

Repeated Violation 12/3/24, et al.

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

1/30/2026 The maintenance team immediately replaced and dated all batteries dated 1/29/2026. Total of 33 carbon monoxide alarms in the building.
On 1/30/2026 The Executive Director retrained the maintenance team in regards to Carbon Monoxide alarms Standards.
Ongoing The Maintenance Director will date all batteries when they are changed yearly and as needed. To Ensure compliance there is a reminder in our TELS system that all carbon monoxide batteries will be changed on 1/2/2027. ED or designee will check TELS to confirm completion each year.

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

Implemented (█ - 06/09/2026)

42b - Abuse

4. Requirements

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

42b Abuse *(continued)*

Description of Violation

Resident #1 is diagnosed with Dementia and resides in the Secure Dementia Care Unit of the home. Resident #1's assessment dated [redacted] indicated the resident ambulates independently with no use of mobility devices and has moderate problems with irritability and severe problem with aggression. Resident #1's support plan, dated [redacted] includes a plan to meet Resident #1's need by redirecting Resident #1 when [redacted] becomes upset or aggressive with care.

On 5/3/25 towards the end of an 11:00 PM 7:00 AM shift, Resident #1 required personal care but was refusing to walk from the common areas to the resident's bedroom. Resident #1 became combative and refused to walk to [redacted] bedroom, so Staff Members A and B placed Resident #1 into a wheelchair to transport Resident #1. Staff Member B stated, "we used the wheelchair because [redacted] didn't want to go" and to get Resident #1 to [redacted] room quickly so [redacted] could be changed prior to the end of the shift. Resident #1 continued to exhibit agitation and aggression towards Staff Members A and B by swinging [redacted] arms to hit staff and kicking [redacted] legs. Staff Member A indicated [redacted] was swinging on us, [redacted] can't see us in a wheelchair so that was a better option". Upon arrival to Resident #1's bedroom, Resident #1 stood and attempted to turn and hit Staff Member A. Resident #1 was reported to trip and fall to the floor; Resident #1 rubbed [redacted] leg and stated it hurt after the fall. Staff Member C observed Staff Members A and B pushing Resident #1 in a wheelchair, "taunting" the resident and reported the incident to Staff Member D. Staff Member D checked on Resident #1 after the incident and indicated Resident #1 was crying stating "I m in pain and afraid". Staff Member C assessed Resident #1 on the morning of [redacted] and found bruises on the inside and outside of Resident #1's right and left wrists that were not observed upon an intial assessment completed on [redacted]

Repeated Violation 3/13/25

Plan of Correction ***Accept ([redacted] - 03/13/2026)***

Initial steps taken: Staff member A and B were suspending pending the investigation. Staff member D was terminated for late reporting of suspected abuse.
Staff Members A and B Were suspended per investigation and pending Area of aging investigation and internal investigation. Staff Member A and B are no longer employed at Brookdale Grandon Farms.
1/30/2026 Direct Care and Clinical Management staff were retrained by the ED on the community policy regarding residents with dignity and respect as documented in the Residents Rights.
A community retraining was completed on 2/25/2026 @ 2:30 p.m. by OAPSA representative from the area of Aging on Mandated Reporting of allegations of abuse/neglect.
3/9/2026 The Executive Director did additional training to all clinical staff on the importance of the following: Positive redirection and sensitivity, allowing residents adequate time for their ADL's from their assessment and not rushing residents
Ongoing The ED, clinical management team will continue to promote resident dignity at orientation, dementia training, annual trainings and during monthly staff meetings and whenever indicated.
Ongoing To assist with compliance, The ED or designee will review any potential incidents as they occur daily for one (1) month starting 2/1/2026 through 2/28/2026.
Ongoing The Executive Director will implement on going audits to any potential incidents that may occur in the community by reviewing any incidents of potential abuse monthly at staff meetings and yearly trainings. To prevent further occurrences The Executive Director will review Allegations of abuse, restraints, allowing residents efficient time for ADL's according to their care plan.

42b - Abuse (continued)

Following, reviews by the ED or designee will occur weekly for one (1) additional month starting 3/1/2026 and ending 3/31/2026 to verify compliance and to determine if any further action is warranted.

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

Implemented (█ - 06/09/2026)

100b - Removal Snow/Obstructions

5. 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 1/28/26 at approximately 9:20 AM, snow and ice accumulation was observed on the exterior walkway and bottom of the stairwell of the exit located near the Secured Dementia Care Unit.

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

1/29/2026- The Maintenance Director immediately removed the snow on the exterior walkway of the stairwell of the exit located near the Secured Dementia unit.
1/30/2026- The Executive Director retrained the Maintenance team on snow removal/Obstructions.
2/1/2026- The Maintenance Director will conduct weekly audits X 4 weeks audits to exterior walkways starting on 2/1/2026 through 2/28/2026 and then monthly for two (2) months starting 3/1/2026 and ending on 4/30/2026.
2/1/2026- The Executive Director or designee will review audits to verify if any further action is warranted.

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

Implemented (█ - 06/09/2026)

121a - Unobstructed Egress

6. 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 1/28/26 at approximately 9:20 AM, ice and snow covered the walkway, and the bottom of the stairwell exit door near the Secured Dementia Care Unit obstructing the egress route as the door was unable to be pushed open.

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

1/29/2026- The Maintenance Director immediately removed the snow on the exterior walkway of the stairwell of the exit located near the Secured Dementia unit.
1/30/2026- The Executive Director retrained the Maintenance team on snow removal/Obstructions.
2/1/2026- The Maintenance Director will conduct weekly audits to exterior walkways X 4 weeks starting on 2/1/2026 through 2/28/2026 and then monthly for two (2) months starting 3/1/2026 and ending on 4/30/2026.

121a - Unobstructed Egress (continued)

2/1/2026- The Executive Director or designee will review audits to verify if any further action is warranted.

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

Implemented (█ - 06/09/2026)

132c - Fire Drill Records

7. Requirements

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

Description of Violation

The fire drill record for the drills conducted on 7/17/25, 8/4/25, 10/8/25, 11/29/25, and 12/30/25 did not include the amount of time it took for evacuation.

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

1/30/2026- The Executive retrained the Maintenance team on fire Drill records.
2/1/2026- The Executive Director properly recorded the fire drill in min/sec on the following dates: 7/17/2025,8/4/2025,10/8/2025,11/29/2025 and 12/30/2025.
2/1/2026- The maintenance Director or designee will complete monthly audits x two (2) months to verify fire drills are completed and documented as per company policy beginning on 2/1/2026 and ending on 3/31/2026 to ensure compliance.
To assist with ongoing compliance, the form will be audited by the Executive Director or designee for two (2) months starting on 2/1/2026 and ending on 3/31/2026.

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

Implemented (█ - 06/09/2026)

171b5 - First Aid Kit

8. 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

On 1/29/26, the first aid kit in the home's Ford van, used to transport residents, did not include a thermometer.

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

Immediately the Clare Bridge Manager replaced the thermometer that was missing on the first aid kit on the bus.
1/30/2026- The Executive Director retrained the appropriate staff on the community policy regarding first aid kits.
The Maintenance Director will do weekly audits on the first aid kit on the bus to verify thermometer are included

171b5 - First Aid Kit (continued)

and the first aid kit is complete weekly for one (1) month starting 2/1/2026 through 2/28/2026 then starting for one (1) month on 3/1/2026 then ending on 3/31/2026 to ensure compliance.
The Executive Director or designee will review the audits results to verify if any further action is warranted

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

Implemented (- 06/09/2026)

183b - Meds and Syringes Locked

9. 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 1/29/26 at 10:35 AM, a bottle of Meloxicam 15mg tablets was unlocked, unattended and accessible in a cabinet in the 500-hallway kitchenette.

On 1/29/26 at 11:30 AM, a 15-ounce tub of A+ Health Healing Ointment Zinc Oxide 20% skin protectant and a 14-ounce bottle of Ammonium Lactate 12% lotion with a prescription label were unlocked, unattended, and accessible in Resident #6's bedroom.

Repeated Violation- 12/3/24, et al.

Plan of Correction ***Accept (- 03/13/2026)***

On 1/29/2026 the bottle of meloxicam was immediately removed from the 500-hallway kitchenette.
On 1/29/2026 Resident #6 was educated on locking door when leaves to secure any medication that is allowed to have at bedside.
1/30/2026- Current staff were retrained on prescription medications that they shall be kept in an area or container that is locked.
On 1/30/2026- The health and Wellness Director did an initial audit of all resident's room on the 500- hall and found no other medications in any rooms.
Ongoing- The Health and Wellness Director or designee will do weekly room audits on the 500-hall total of 14 rooms and audit 7 rooms weekly starting on 2/1/2026 to verify compliance ending on 2/28/2026.
Random audits will be completed on the 500-hall monthly for two months total of 14 rooms.
To assist with Ongoing compliance the health and wellness Director or designee will complete weekly bedroom audits for two (2) months starting on 2/1/2026 and ending on 3/31/2026.
To assist with ongoing compliance, the Executive Director or designee will review all audits for two (2) months to verify compliance ending on 3/31/2026

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

Implemented (- 06/09/2026)

184a - Resident's Meds Labeled

10. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 is prescribed Synthroid 88 mcg oral tablet, take one tablet by mouth at bedtime. However, the pharmacy label provided instructions to take one tablet by mouth daily in the morning on an empty stomach.

Plan of Correction ***Accept (- 03/13/2026)***

1/30/2026- The Executive Director retrained all appropriate clinical staff on proper documentation of insulin in units. Staff member E was trained by the Executive Director.
2/1/2026- An initial audit was completed by the Health and Wellness Director of glucometers for documentation and the community policy regarding the use of glucometers and the importance of accurate calibration of date and time and no others were out of compliance.
An audit of the EMAR will be completed to match the documentation with the EMAR to the insulin given to ensure accuracy. This will be completed by the Health and Wellness Director or designee for two (2) months starting 2/1/2026 and ending on 3/31/2026.
To assist with ongoing compliance, the EMAR will be audited weekly by the Executive Director or designee for two (2) months starting on 2/1/2026 and ending on 3/31/2026.

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

Implemented (- 06/09/2026)

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

Resident #7 receives blood glucose checks three times a day, before meals. On 1/15/26 at 7 AM, Resident #7's January 2026 Medication Administration Record indicated the resident's blood glucose was 81. However, Resident #7's glucometer indicated a blood glucose reading of 98 at 12:43. Resident #7's glucometer was not calibrated to the correct time and the resident's blood glucose reading was not documented accurately.

Plan of Correction ***Accept (- 03/13/2026)***

1/30/2026- The health and Wellness Director retrained the Medication Technician's on the process for documentation of glucose results when transferring the number from the glucometer to the EMAR. A review was completed of documentation of glucometers as compared to the EMAR and found to be in compliance.
2/1/2026- An audit was completed by the Health and Wellness Director of glucometers for documentation and the community policy regarding the use of glucometers and the importance of accurate calibration of date and time

185a - Implement Storage Procedures (continued)

and no others were out of compliance.
A glucometer audit form will be implemented to review date, time and matching documentation with the EMAR to the glucometer. This will be completed by the Health and Wellness Director or designee for two (2) months starting 2/1/2026 and ending on 3/31/2026.
To assist with ongoing compliance, this form will be audited weekly by the Executive Director or designee for two (2) months starting on 2/1/2026 and ending on 3/31/2026.

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

Implemented (- 06/09/2026)

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:
6. Dose.

Description of Violation

Resident #7 is prescribed Lantus Subcutaneous Solution 100 unit/ml, Inject 30 IU subcutaneously one time a day. On 1/16/26, 1/19/26, 1/21/26, 1/24/26, and 1/28/26, Resident #7's January 2026 Medication Administration Record (MAR) indicated 35 IU was administered. Staff Member E confirmed 30 IU was administered on these dates; however, the wrong dose was documented on the resident's MAR.

Repeated Violation- 12/3/24, et al.

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

1/30/2026- The Health and Wellness Director immediately had staff member E correct the dose administered in resident #7's MAR.
1/30/2026- The Executive Director retrained the appropriate clinical staff on medication record and documentation.
1/30/2026- The Health and Wellness Director did an initial audit and found documentation correct.
2/1/2026- The Health and Wellness Director will audit the MAR weekly for one month starting 2/1/2026 and ending on 2/28/2026 then for one (1) month beginning on 3/1/2026 and ending on 3/31/2026 to ensure compliance.
To assist with ongoing compliance, will be audited by the Executive Director or designee for two (2) months starting on 2/1/2026 and ending on 3/31/2026.

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

Implemented (- 06/09/2026)

202 - Prohibitions

13. Requirements

2600.
202. The following procedures are prohibited:

202 Prohibitions *(continued)*

4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.

Description of Violation

Resident #1's assessment, dated [redacted], indicated Resident #1 ambulates independently and uses no assistive devices. On [redacted] Staff Members A and B utilized a wheelchair to restrict Resident #1's movement when the resident refused to walk to [redacted] bedroom and became combative. Staff Member B reported to an agent of the Department, that Resident #1 was placed in the wheelchair "to get [Resident #1] to [redacted] room quickly", "because [redacted] didn't want to go". Staff Member B also stated while being transported in the wheelchair, Resident #1 continued to be aggressive and resistant, swinging [redacted] arms and kicking [redacted] legs. Staff Member A stated the wheelchair was used because [redacted] was swinging on us, [redacted] can't see us in a wheelchair, so that was a better option". Pushing Resident #1 in a wheelchair limited the resident's movement and prohibited the resident from readily and independently exiting the wheelchair at will.

Plan of Correction ***Accept ([redacted] - 03/13/2026)***

1/30/2026 The Appropriate clinical staff were retrained on the regulation and Brookdale policies and procedures regarding the community policy on restraints.
3/9/2026 Additional training was completed on the following topics: not rushing care for residents, allowing residents adequate time to complete their ADLs per their assessment and resident's rights and positive redirection and sensitivity training.
Staff Member A and B were suspended immediately upon being notified of suspected abuse pending internal investigation from Brookdale and Area of Aging. Staff members A and B are no longer employed at Brookdale.
Ongoing Compliance The Executive Director will implement continued trainings at Monthly staff meetings, annual trainings and whenever warranted to assist with continued compliance on restraints.

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

Implemented ([redacted] - 06/09/2026)

225c - Additional Assessment

14. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

225c Additional Assessment *(continued)*

Description of Violation

Resident #7's assessment, dated [redacted] indicated the resident ambulates independently; However, Resident #8 utilizes a wheelchair for ambulation. Resident #7's assessment was never updated to reflect the resident's change in need.

Resident #8's assessment, dated [redacted] indicated the resident has no problems in areas of irritability, agitation or hallucinations. However, interviews with staff on 1/29/26 indicated the resident becomes withdrawn and nonverbal, gives push back when medication is administered, and communicates with visual hallucinations. The resident's assessment has not been updated to reflect the behavioral/cognitive needs of the resident.

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

1/30/2026 The Executive Director retrained the Health and Wellness Director on the community and state regulation on additional assessment.
1/30/2026 The Executive Director immediately completed an Addendum to Resident #7's assessment to include that the resident utilizes a wheelchair.
1/30/2026 The Executive Director immediately completed an Addendum for Resident #8's assessment to include behavioral and cognitive need.
2/1/2026 The Health and Wellness Director will do an audit of 5 charts weekly for one (1) month starting on 2/1/2026 and ending on 2/28/2026 and if any assessments out of compliance will be updated at time of audit. Additional for one (1) month starting on 3/1 2026 ending on 3/31/2026 will audit 5 more charts to verify compliance.
To assist with ongoing compliance, this form will be audited by the Executive Director or designee for two (2) months starting on 2/1/2026 and ending on 3/31/2026 to verify if any further action is warranted.

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

Implemented ([redacted] - 06/09/2026)