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

May 6, 2026

[redacted], COO
CARE HSL HARLEYSVILLE OPCO LP
[redacted]

RE: THE BIRCHES AT HARLEYSVILLE
691 MAIN STREET
HARLEYSVILLE, PA, 19438
LICENSE/COC#: 14266

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/03/2026, 02/04/2026 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: *THE BIRCHES AT HARLEYSVILLE* **License #**: *14266* **License Expiration**: *03/27/2026*

Address: *691 MAIN STREET, HARLEYSVILLE, PA 19438*

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

Administrator

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

Legal Entity

Name: *CARE HSL HARLEYSVILLE OPCO LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I 1* **Date**: *11/12/2021* **Issued By**: *Lower Salford Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *114* **Waking Staff**: *86*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *02/04/2026*

Inspection Dates and Department Representative

02/03/2026 On Site: [redacted]

02/04/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak and Garden* **Capacity**: *34* **Residents Served**: *30*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *71*

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

Have Mobility Need: *42* **Have Physical Disability**: *5*

Inspections / Reviews

02/03/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *03/22/2026*

Inspections / Reviews *(continued)*

04/03/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/22/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/13/2026*

04/14/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/13/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/19/2026*

05/06/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/17/2026*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 11/10/2025, at 3:58 pm, Resident 1 reported they were missing $100.00. This incident was reported to staff person A on 11/10/2025 at around 3:58 pm. However, this allegation of abuse was not reported to the local area agency on aging.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation was corrected when the Executive Director made an oral report to the Montgomery County Agency on Aging on 2/5/2026, followed by a written report to the DHS.

Additional Corrective Actions: The management team of department directors will be trained by the Executive Director on the regulatory requirements for reporting incidents and the process for making timely oral reports to Montgomery County Agency on Aging by 4/3/2026.

Beginning 3/25/2025, The Executive Director, Resident Care Director and Memory Care Director will review incidents at daily Huddle, to ensure that all required reports are completed.

Ongoing Quality Assurance Actions: The Executive Director will review all ACT 13 reporting and ensure timely reporting as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

16c - Written Incident Report

2. 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 11/10/2025, Resident 1 reported to Staff Person A that they were missing $100.00 from their room. The home did not submit an incident report to the Department.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation was corrected when the Executive Director reported the suspected abuse to BHSL via written report on 2/6/2026.

Additional Corrective Actions: The management team of department directors will be trained by the Executive Director on the regulatory requirements for reporting incidents and properly reporting suspected abuse timely by 4/3/2026.

16c - Written Incident Report (continued)

Beginning 3/24/2026, the Executive Director, Resident Care Director, and Memory Care Director will review incidents at the daily Huddle, to ensure all required reports are completed.

Ongoing Quality Assurance Actions: The Executive Director will review all reportable incidents and the actual reports submitted as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

42b - Abuse

3. Requirements

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

Description of Violation

In November 2025, Resident 1 noticed they were missing $100.00 from room. Resident 1 is not sure of the date the money went missing. The missing money was reported to Staff person A on 11/10/2025. Staff Person A filed a police report for the missing money.

On 11/6/2025, Resident 2 reported to Staff Person B they were missing $200.00 from their drawer. Resident 2 used to have private hair appointments in their room. During these sessions, Resident 2 would provide Staff Person C tips in cash. During one of these sessions, Staff Person C became aware of where the resident stores cash in the room. Resident 2 no longer feels safe keeping money in their room.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: On 11/7/25 and 11/10/25, The Executive Director credited the respective residents for missing money on their monthly account statements. Both residents were offered safes for their rooms, by the Executive Director on the dates the missing money was reported.

Additional Corrective Actions: The Executive Director met with PS Salon District Leader on 3/18/2026 to review that all services must be provided in the PS Salon on site. The Executive Director will have a meeting with PS Salon HR Director by 4/3/2026 to ensure cash payments and tips are not rendered by residents.

The Executive Director will complete an audit on five residents that utilize PC Salon to ensure compliance by 4/3/2026.

At the next Town Hall meeting in April 2026, the Executive Director will review with residents their payment options for the Hair Salon, as well as the availability of locking boxes and safes to safeguard money and valuables.

Ongoing Quality Assurance Actions: Ongoing compliance will be reviewed as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

42b - Abuse *(continued)*

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

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

51 - Criminal Background Check

4. Requirements

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

Description of Violation

Staff Person C, hired in [redacted] did not have a criminal background check thru the Pa Patch system.

Staff Person D, hired in [redacted] did not have a criminal background check thru the Pa Patch system.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The Business Office Manager will complete PA Patch system checks with Staff person C and Staff Person D by 3/22/2026.

Additional Corrective Actions: The Executive Director met with the District Leader from PA Salon to review PA Patch System and regulatory requirements for current employees and all new employees 4/3/2026.

On 3/19/2026, the Executive Director reviewed with the Business Office Manager the requirements for obtaining and maintaining record of these checks for contracted workers in the community.

The BOM will complete an audit of all contracted workers to ensure background checks are completed and available, by 4/3/2026.

Ongoing Quality Assurance Actions: The Business Office Manager will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

54a - Direct Care Staff

5. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person E, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

54a - Direct Care Staff *(continued)*

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The Executive Director submitted a Waiver to the Bureau of Human Services Licensing on 2/3/2026. Staff person E was removed from the schedule until Waiver approved on March 2, 2026.

Additional Corrective Actions: The Executive Director provided education to the BOM regarding the requirements of 2600.54 on 4/3/2026.

The Business Office Manager will complete an audit of our current employees to ensure that all employees meet qualifications listed under 2600.54a by 4/3/2026.

Ongoing Quality Assurance Actions: The Business Office Manager will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

82c - Locking Poisonous Materials

8. 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

Crest Scope Toothpaste, with a manufacture's label indicating "to contact poison control", was unlocked, unattended, and accessible to residents 3. Not all the residents of the home, including 3, have been assessed capable of recognizing and using poisons safely.

Secret Deodorant, with a manufacture's label indicating "to contact poison control", was unlocked, unattended, and accessible to residents 3. Not all the residents of the home, including 3, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation was immediately corrected during the annual inspection on 2/3/2026 when the Med Tech locked up the poisonous materials.

Additional Corrective Actions: The Memory Care Director will provide in-service for all memory care staff related to all poisonous materials being locked and inaccessible to residents that are unable to safely use or avoid poisonous materials by 4/3/2026.

On the day of the inspection, 2/3/26, the Memory Care Director checked all memory care resident rooms to secure all poisonous materials.

Ongoing Quality Assurance Actions: Beginning 3/25/2026, the Memory Care Director will do a daily walk through the memory care neighborhood, and secure any poisonous materials found in common areas.

The Memory Care Director will complete weekly audits on five resident rooms to ensure compliance beginning

82c Locking Poisonous Materials (continued)

3/24/2026. The Memory Care Director will report on ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

100b - Removal Snow/Obstructions

9. 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 2/3/2025 at 9:30 am, The home did not have a cleared path to the gate used for an emergency exit. The home had an accumulation of ice and snow on the path.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation was corrected by the maintenance department, by clearing a path to the gate used as an emergency exit during our annual inspection on 2/3/2026.

Additional Corrective Actions: The Maintenance Director will provide training to [redacted] department on the regulatory requirements for removal of snow and obstructions by 4/3/2026.

On 2/3/26, the Maintenance Director checked all exits to make sure all were clear of snow and obstructions.

Ongoing Quality Assurance Actions: The Maintenance Director will implement the use of daily round exterior protocol, as part of the daily walkthrough of the interior and exterior of the community, by 4/3/2026. The Maintenance Director will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

101j7 - Lighting/Operable Lamp

10. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 3 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation was corrected by the Maintenance Director providing a working light on the bedside stand during our annual survey on 2/3/2026.

Additional Corrective Actions: The Maintenance Director will provide in service to housekeeping and maintenance department related to regulation to ensure an operative lamp or other source of lighting that can be turned on at

101j7 - Lighting/Operable Lamp (continued)

bedside is maintained, by 4/3/2026.

All resident rooms were checked for a bedside light source by the Maintenance Director by 4/3/2026.

Ongoing Quality Assurance Actions: Beginning 4/3/2026, the Maintenance Director will complete weekly audits on five resident rooms to ensure compliance. The Maintenance Director will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026

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

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

105g - Lint Removal and Duct Cleaning

11. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 2/3/2026, there was an approximate 1/2 inch accumulation of lint in the lint trap of the Main Laundry room. There were no clothes in the dryer at the time.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation was corrected by the Maintenance Director removing the accumulated lint during our annual inspection on 2/3/2026.

Additional Corrective Actions: The Maintenance Director will in-service the maintenance and housekeeping department on regulatory requirements related to removing lint from dryers after each use by 4/3/2026.

On 2/3/2026, all dryers were checked for lint accumulation by the Maintenance Director.

Ongoing Quality Assurance Actions: Beginning 4/3/2026, the Maintenance Director will complete weekly audits on all dryers to ensure compliance. The Maintenance Director will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March in April 2026.

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

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

141a 1-10 Medical Evaluation Information

13. Requirements

2600.

141a 1 10 Medical Evaluation Information *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 4's medical evaluation did not include the license number of the provider.

Resident 5's medical evaluation did not include the license number of the provider.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: On 4/3/2026, the DMEs were updated by the provider to include the license number.

Additional Corrective Actions: The Executive Director will provide education to [redacted] related to the regulation to include license number on the medical evaluation by 4/10/2026.

The Wellness Supervisor will audit all medical evaluations for existing residents to ensure license number is included on the medical evaluation by 4/10/2026.

Ongoing Quality Assurance Actions: The Wellness Supervisor will audit medical evaluations completed by physician weekly to ensure compliance, beginning on 4/3/2026. The Resident Care Director will audit 5% of the resident records each month, including the completion of each DME, beginning 4/3/2026.

The Executive Director will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

141b1 - Annual Medical Evaluation

14. Requirements

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

Description of Violation

Resident 6's medical evaluation did not include the license number of the provider.

Resident 7's medical evaluation did not include the license number of the provider.

141b1 Annual Medical Evaluation *(continued)*

Plan of Correction ***Accept (- 04/03/2026)***

Immediate Corrective Actions: On 4/3/2026, the DMEs were updated by the provider to include the license number.

Additional Corrective Actions: The Executive Director will provide education to [redacted] related to the regulation to include license number on the medical evaluation by 4/10/2026.

The Wellness Supervisor will audit all medical evaluations for existing residents to ensure license number is included on the medical evaluation by 4/10/2026.

Ongoing Quality Assurance Actions: The Wellness Supervisor will audit medical evaluations completed by physician weekly to ensure compliance, beginning 4/3/2026.

The Resident Care Director will audit 5% of the resident records each month, including the completion of each DME, beginning 4/3/2026.

The Executive Director will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

Implemented (- 04/14/2026)

162c - Menus Posted

15. 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 2/1/2026 was posted. However, the menu for the following week was not posted in the Garden Memory care unit.

The home's menu for the week of 2/1/2026 was posted. However, the menu for the following week was not posted in the Daybreak Memory care unit.

The home's menu for the week of 2/1/2026 was posted. However, the menu for the following week was not posted in the Personal care area.

Plan of Correction ***Accept (- 04/03/2026)***

Immediate Corrective Actions: The Violation was corrected when the Dining Director posted the menus for the current week and next week promptly during our annual inspection on 2/3/2026.

Additional Corrective Actions: The Executive Director educated the Dining Director on the regulatory requirement to post two weeks of menus at each dining location on 4/3/026.

162c - Menus Posted (continued)

Ongoing Quality Assurance Actions: The Dining Director will complete an audit weekly to ensure menus are posted to meet requirements, beginning 4/3/2026.

The Dining Director will report on ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

183b - Meds and Syringes Locked

16. 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 2/3/2026 at 9:24 am, Pain relief medication was unlocked, unattended, and accessible in room 104.

On 2/3/2026 at 9:24 am, Tylenol PM medication was unlocked, unattended, and accessible in room 104.

On 2/3/2026 at 10:25 am, Nyquil Honey Cold and Flu medication was unlocked, unattended, and accessible in room 104.

On 2/3/2026 at 10:25 am, Claritin Allergy medication was unlocked, unattended, and accessible in room 227.

On 2/3/2026 at 10:25 am, Mucus DM extended release medication was unlocked, unattended, and accessible in room 227.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation was corrected during our annual inspection on 2/4/2026 by removing medications from unlocked, unattended and accessible areas by the med tech. Resident was out of the community at [redacted] time of the inspection and [redacted].

Additional Corrective Actions: The Memory Care Director will complete an in-service with med techs and caregivers related to medications being kept in an area that is locked, by 4/3/2026.

Ongoing Quality Assurance Actions: Beginning 4/3/2026, the Memory Care Director will do a daily walk through the memory care neighborhood, and secure any unlocked medications found. The Wellness Supervisor will complete weekly audits on five rooms to ensure compliance, beginning 4/3/2026.

The Executive Director will report on ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

183d - Prescription Current

17. Requirements

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

Description of Violation

On 2/3/2026, Vitamin D 5000 IU prescribed for Resident 9, was in the home's Medication Cart; however, the medication was not on the current orders.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation was corrected at the time of inspection when Med Tech removed the medication from the medication cart and returned to the pharmacy on 2/3/2026.

Additional Corrective Actions: The Memory Care Director will complete education with the med techs related to removing medications from the med cart that are discontinued by 4/3/2026.

All med carts were audited by Med Techs by 4/3/2026 to ensure all discontinued medications were removed, by 4/3/2026

Ongoing Quality Assurance Actions: Med Techs will complete weekly cart audits to ensure medications that are discontinued are removed from the medication cart, beginning 4/3/2026.

The Executive Director will report on ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

183e - Storing Medications

18. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 2/3/2026 Lantus Pen belonging to Resident 9, was not labeled with open date. According to the manufacturer's instructions this medication expires after 28 days.

On 2/3/2026 Latanoprost eye drop belonging to Resident 10, was opened 11/23/2025, According to the manufacturer's instructions this medication lasts only 6 weeks once opened.

On 2/3/2026, Tramadol 50 mg TIB belonging to Resident 11 Slot #41 was broken with pill still inside.

On 2/3/2026, Latanoprost eye drop belonging to Resident 12 was opened 9/15/2025, According to the manufacturer's instructions the medication lasts only 6 weeks once opened.

183e - Storing Medications (continued)

On 2/3/2026, Lorazepam .5 mg belonging to Resident 13 expired on 8/6/2025 but remained in the medication cart.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The med tech removed and reordered all medications from the med cart for resident 9, resident 10, resident 12 and resident 13 on the date of inspection on 2/3/2026. The med tech removed resident #11 medication in slot #41 to destroy on 2/3/2026.

Additional Corrective Actions: The Memory Care Director will provide in-services for Med Techs related to expired medication, manufacturer instructions, broken pill packaging, labeling medication with open date, by 4/3/26.

All med carts will be audited by Med Techs by 4/3/26to ensure all medications are stored appropriately.

Ongoing Quality Assurance Actions: Med Techs will complete weekly cart audits to ensure compliance, beginning 4/3/26. The Executive Director will report on ongoing compliance and as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

184a - Resident's Meds Labeled

19. Requirements

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

Description of Violation

Collagenance Santyl Ointment belonging to Resident 9 did not have a pharmacy label on it that included the Resident's name.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation was corrected by the Memory Care Director on the date of the inspection on 2/3/2026 by removing this medication from the med cart and reordering with an appropriate label.

Additional Corrective Actions: The Memory Care Director will provide in-service to Med Techs related to ensuring that medications have a pharmacy label that includes the resident's name.

Ongoing Quality Assurance Actions: Med Techs will complete weekly cart audits to ensure compliance, beginning

184a - Resident's Meds Labeled (continued)

4/3/2026. The Executive Director reviews ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026

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

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

185a - Implement Storage Procedures

20. 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 2/3/2026 at 10:19 am, Resident 9's Glucometer displayed 11:13 am.

Resident 14's Tramadol 50 mg Q12 prn was signed out and initialed however the home is not documenting whether it is AM or PM.

On 2/3/2026 at 1:45 pm, Resident 15's glucometer displayed 2:40 pm.

On 1/28/2026 at 12;17 pm, Resident 15's glucometer had a reading of 125 but was documented on the Medication administration record as 120.

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Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation was corrected when the glucometer times were changed for Resident # 9 and Resident # 15 by the Memory Care Director and Wellness Supervisor on 3/10/2026. The violation for resident #15 was reported to DHS on 3/18/2026.

Additional Corrective Actions: By 4/3/2026 the Med Techs will be trained by the Memory Care Director related to Glucometer display times being updated weekly, as well as including an indication of AM or PM for PRN meds and checking the glucometer reading 3 times to verify the documentation matches it.

Ongoing Quality Assurance Actions: The Wellness Supervisor will audit the Glucometer weekly to ensure compliance, beginning 4/3/2026. The Executive Director will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

185b - Medication Procedures

21. Requirements

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

185b Medication Procedures *(continued)*

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

Description of Violation

On [redacted] Resident 16 returned to the home from [redacted], upon return the resident was missing 3 pills of Oxycodone/APAP 7.5 325 Tab, However the home could not account for the missing medication.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation could not be corrected due to the resident not returning with the medication. The missing medication was reported to DHS on 1/1/2026, by the Executive Director.

Additional Corrective Actions: The Executive Director implemented a process on 3/9/2026 to ensure medications are counted when signed out of the community and again on return to the community. Staff were trained by the Executive Director on this process on 4/3/2026.

Ongoing Quality Assurance Actions: The Executive Director will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

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

187b - Date/Time of Medication Admin.

22. 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

Resident 11 is prescribed Morphine .25 ml . Resident 11's Morphine .25 ml medication administration record does not include the initials of the staff person who administered Morphine .25 ml on 1/13/2026 at 3:30 pm.

Resident 17 is prescribed Hydrocod APAP 5 325 mg. Resident 17's Hydrocod APAP 5 325 mg medication administration record does not include the initials of the staff person who administered Hydrocod APAP 5 325 mg on 2/3/2026 at 9:41 am.

Resident 18 is prescribed Morphine .25 ml Q2 PRN . Resident 18's Morphine .25 ml medication administration record does not include the initials of the staff person who administered Morphine .25 ml on 1/09/2026.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: Unable to correct MAR due to time elapsed. Note made in resident records by Executive Director on 3/23/2026.

Additional Corrective Actions: Med Techs identified and education provided by Memory Care Director on 4/3/2026

187b - Date/Time of Medication Admin. (continued)

Ongoing Quality Assurance Actions: Wellness Supervisor will audit five records weekly to ensure documentation compliance, beginning 4/3/2026.

The Executive Director will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

Implemented ([redacted] - 05/06/2026)

187d - Follow Prescriber's Orders

23. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 15 is prescribed Lispro. However, Resident 15 was administered 4 units on 1/27/2026 at 9:00 pm. Resident 15's orders stated to be administered 2 units.

Resident 18 is prescribed Novolog. However, resident 18 was administered 4 units on 1/25/2026 at 5:00 pm, Resident 18's orders state to be administered 2 units.

Resident 18 is prescribed Novolog. However, Resident 18 was administered 2 units on 1/25/2026 at 5:00 pm but should have received 0 units.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The errors for Resident #15 were reported to the physician, resident, responsible party, and BHSL by the Executive Director on [redacted] Resident #18 had passed away and was made inactive, and thus, the medication error was not reported.

Additional Corrective Actions: Med Techs identified were provided education on 2/10/2026, by the Executive Director.

Ongoing Quality Assurance Actions: Wellness Supervisor and Memory Care Director completing weekly audits of MARS and insulin administration, beginning 4/3/26.

The Executive Director will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

Implemented ([redacted] - 05/06/2026)

251b - Record Entries Legible

24. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

251b Record Entries Legible *(continued)*

Description of Violation

Resident 17's Alprazolam 1 mg at bedtime sign out sheet was written over and not legible.

Plan of Correction ***Accept ([redacted] - 04/03/2026)***

Immediate Corrective Actions: The violation was unable to be corrected due to documentation noted on resident #17's record.

Additional Corrective Actions: Med Tech identified and education provided by Memory Care Director on 2/10/2026.

Ongoing Quality Assurance Actions: The Wellness Director will audit five records weekly to ensure compliance, beginning 4/3/2026.

The Executive Director will report ongoing compliance as part of our quarterly QA meeting, beginning with a review of Q1 2026 (January, February, and March) in April 2026.

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

Implemented ([redacted] - 05/06/2026)