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

May 21, 2026

[redacted], VICE PRESIDENT OF OPERATIONS
THE ECUMENICAL COMMUNITY
3525 CANBY STREET
HARRISBURG, PA, 17109

RE: ECUMENICAL RETIREMENT
COMMUNITY OF HARRISBURG III
3525 CANBY STREET
HARRISBURG, PA, 17109
LICENSE/COC#: 31021

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: *ECUMENICAL RETIREMENT COMMUNITY OF HARRISBURG III* **License #**: *31021* **License Expiration**: *07/04/2026*

Address: *3525 CANBY STREET, HARRISBURG, PA 17109*

County: *DAUPHIN* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *THE ECUMENICAL COMMUNITY*

Address: *3525 CANBY STREET, HARRISBURG, PA, 17109*

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *02/27/2001* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *59* **Waking Staff**: *44*

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: *136* **Residents Served**: *29*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Connections* **Capacity**: *38* **Residents Served**: *29*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *30*

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

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

02/03/2026 - Full

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

Inspections / Reviews *(continued)*

03/24/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/02/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/03/2026*

05/21/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/02/2026*

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 12/5/25 at approximately 9:40 AM, Resident #1 was found in Resident #2's bedroom partially clothed. Resident #2 admitted to touching Resident's #1's [redacted] while the resident was lying in bed. This allegation was not reported to the local police or to Pennsylvania Department of Aging as required by the Older Adults Protective Services Act.

Repeated Violation - 4/10/25, 11/8/24

Plan of Correction ***Accept ([redacted] - 03/24/2026)***

On 12/5/2025 statements were received from co-workers who witnessed incident minus the touching that was not witnessed however admitted to later on to Campus Executive director by resident #2 in SDCU.

12/5/2025 Connections Manager called AAA @ 11:28am to report not serious sexual abuse and spoke to [redacted] no indication from AAA that this would be serious sexual abuse

12/5/2025 Connections Manager emailed state reportable to DHS @ 11:28am
12/5/2025 Connections Manager faxed written report to AAA @11:45am
12/5/2025 Connections Manager had an educational in-service with staff on abuse and reporting at 1:30pm and 3:30pm
12/5/2025 Nursing did head to toe assessments on both resident #1 and resident #2 no marks or injuries
12/5/2025 PCP notified for resident #1 and order received for [redacted]
12/5/2025 PCP notified for resident# 2 and order received for [redacted]
12/5/2025 POAS notified for both resident #1 and resident #2
12/5/2025 Resident #1 and resident #2 [redacted].

All staff will continue to use the abuse reporting flow chart provided by BHSL.

Campus Executive Director will alter checklist for re-portable incidents involving abuse to include a detail over view with Campus ED on sexual abuse for contacting 911 on March 9th 2026

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

Implemented ([redacted] - 05/21/2026)

18 - Compliance With Laws

2. 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 of 2016 states that batteries shall be labeled with the date of installation and replaced at least once annually or at such time as the unit signals a drained or failing battery,

18 Compliance With Laws (continued)

whichever is sooner. The batteries in the carbon monoxide alarms had labels indicating that they were last changed 1/1/25.

Plan of Correction ***Accept (- 03/24/2026)***

1/29/26 Campus Maintenance Director was suspended d/t not performing duties appropriately which included maintaining compliance and procedures which ended in termination.

On February 3rd 2026 Campus Executive Director Instructed Maintenance Associates to check and replaces all carbon monoxide batteries.

On February 4th 2026 Maintenance Associates replaced all batteries and dated them. Photos provided.

On February 26th Campus Executive Director had an educational in service with all of maintenance on policy and procedures surrounding Carbon Monoxide detectors and maintaining compliance.

Beginning February 9th 2026 Maintenance Associate will fill out Carbon Monoxide Weekly Inspection log where it states last time the batteries where change on campus. Carbon Monoxide Detectors will be checked weekly on Wednesdays and the jog will be handed into the Campus Executive Director on Thursdays until a Maintenance Director is hired Documentation to be provided

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

Implemented (- 05/21/2026)

23b - Instrumental Activities of Daily Living Assistance

3. Requirements

2600.
23.b. A home shall provide each resident with assistance with IADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan for Resident #3, dated indicates that the resident has a moderate need for supervision including "regular supervision in the home but will require moderate supervision when outside the home and cannot be left unattended outside of the secured memory care support unit. Staff will ensure [the resident] is supervised at all times when outside of the secured memory support unit." Resident #3 did not receive the supervision as required on 11/22/25 when the resident left the building and was missing from approximately 2:00 PM until 4:14 PM when a staff person found the resident walking approximately four miles from the building.

Plan of Correction ***Accept (- 03/24/2026)***

On 11/22/25 at 2:15pm Campus Executive Director was notified that resident #3 was unable to be located. Campus Executive Director called a code for the campus to initiate looking in all building and on the property for resident #3 as well as contacted family to see if they had taken out without signing out as had a visitor who had out earlier. When could not be located on campus staff was sent out in the community to search and 911 was called for assistance off shift department heads were also called in to search. Officers arrived with drones. Connections Manager located resident #3 on s 28th st by Dauphin County prison.

11/22/25 Family contacted visitor who took resident #3 out who stated gave resident #3 the code to get out of the SDCU knowing that was a wanderer.

23b - Instrumental Activities of Daily Living Assistance (continued)

11/22/25 Campus Executive Director and VPO Contacted IT to get the codes to the SDCU changed so that the old code would no longer work in that neighborhood and changed the photos

11/22/25 5:32pm State Re-portable sent into DHS.
11/22/25 Campus Executive Director Resident#3 sent to Osteopathic for evaluation to ensure [redacted] was without injury . Resident was returned to Ecumenical no injuries or UTI.

Campus Executive Director will have an educational in-service with all staff on Instrumental Activities of Daily Living and what steps need to occur to maintain compliance. Documentation to be provided.

Connections Manager will do an audit beginning March 9th 2026 on the residents in the SDCU neighborhood to ensure they all have the proper safety checks in place to ensure they are being accounted for each shift . Documentation to be provided.

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

Implemented ([redacted] - 05/21/2026)

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.

Description of Violation

On 1/6/26 at 7:20 PM, staff heard screaming in the secured dementia care unit (SDCU), upon investigation they observed Resident #1 being restrained and pinned to a bed by Resident #3. Resident #1 was described by a staff person as appearing scared.

On 12/5/25 at about 9:40 AM, Resident #1 was found in Resident #2's bedroom partially clothed. Resident #2 admitted to touching Resident #1's [redacted] while [redacted] was lying in bed.

On 10/6/25 at 3:15 PM, Resident #4 and Resident #5 got into a verbal argument that escalated into a physical altercation. Resident #4 pushed Resident #5 against a wall causing a small mark to Resident #5's temple and a small cut to [redacted] thumb.

On 5/28/25 at 8:40 PM, Resident #6 and Resident #7 got into a verbal argument that escalated into a physical altercation. Resident #7 pushed Resident #6 causing [redacted] to fall and to sustain an injury requiring treatment at the hospital followed by therapy prior to returning to the home.

Repeated Violation - 4/10/25

Plan of Correction ***Accept ([redacted] - 03/24/2026)***

On 1/6/26 Resident #1 and # 3 were separated by staff Resident #3 had resident #1 pinned down on a bed and [redacted] was screaming. Nurse came down and did full body assessments on both residents. No injuries or bruising noted

42b - Abuse (continued)

on either resident #1 or resident #3 .

1/6/26 Nurse called POA and left voicemail as there was no answer for resident #3 Call PCP office to speak with on call physician.
1/6/26 Nurse called POA and left voicemail as there was no answer for resident #1 Call PCP office to speak with on call physician.
1/6/26 Resident#3 placed on 15 minute checks to ensure [redacted] was not around any other residents
1/7/26 @ 10:40am Connections Manager called AAA and reported to [redacted]
1/7/26 @ 1:40pm AAA report was faxed byv Connections Manager
1/7/26 @ 1:35pm DHS State Reportable was emailed By Connections Manager
1/7/26 Resident #3 was seen by PCP and UAC&S was ordered along with a blood draw on 1/9/26.

1/7/26 POA was notified by Connections Manager and Assistant Director of Nursing resident #3 would need 1:1 services during waking hours until UA results came back and if they came back negative [redacted] would receive a 30 day notice to go to a higher level of care. Family and friends took turns providing 1:1 care
1/7/26 Connections Manager had an Educational In-service @ 10am and at 2pm with [redacted] SDCU team members on abuse reporting the situation that occurred and how to manage a situation as such.
1/13/26 Nursing received UA results that were negative for urinary tract infection.
1/14/26 Senior Helpers began with 1:1 services for waking hours
[redacted] Campus Executive Director issued 30 day involuntary discharge notice to Resident #3 and POA.
Resident #3 discharged to higher level of care.
On 12/5/2025 statements were received from co-workers who witnessed incident minus the touching that was not witnessed however admitted to later on to Campus Executive director by resident #2 in SDCU.
12/5/2025 Connections Manager called AAA @ 11:28am to report not serious sexual abuse and spoke to [redacted] no indication from AAA that this would be serious sexual abuse
12/5/2025 Connections Manager emailed state reportable to DHS @ 11:28am
12/5/2025 Connections Manager faxed written report to AAA @11:45am
12/5/2025 Connections Manager had an educational in-service with staff on abuse and reporting at 1:30pm and 3:30pm
12/5/2025 Nursing did head to toe assessments on both resident #1 and resident #2 no marks or injuries
12/5/2025 PCP notified for resident #1 and order received for [redacted]
12/5/2025 PCP notified for resident# 2 and order received for [redacted]
12/5/2025 POAS notified for both resident #1 and resident #2
12/5/2025 Resident #1 and resident #2 [redacted]
10/6/25 Resident # 5 was came out and was hungry when staff didn't move quickly enough [redacted] got upset calling staff names when resident #4 heard it [redacted] got upset they had words and resident #4 pushed resident #5 against the wall causing a small abrasions to the right temple and right hand thumb. Staff separated them and resident #4 was redirected to [redacted] room.
10/6/25 Director of Nursing came down to do full body assessments on both resident #4 and resident #5
10/6/25 Director of Nursing called PCP and requested [redacted] on resident#4 after explaining altercation.
10/6/25Director of Nursing called PCP and requested [redacted] on resident#5 after explaining altercation.
10/6/25 Resident #4 and resident #5 placed on UTI protocol per nursing judgement.
10/6/25 Connections Manager placed both resident #4 and resident #5 on 30 minute checks.
10/6/25 Connections Manager reported via phone to AAA at 3:15pm
10/6/25 Connections Manager reported to AAA via fax at 5:04pm

42b Abuse (continued)

10/6/25 Connections Manager sent State Reportable via email to DHS at 4:52pm
10/6/25 Connections Manager and Clinical Resource Director had a behavior huddle with the staff on resident # 5 and what could be done to minimize [redacted] behaviors and outbursts to avoid this situation in the future. Documentation to be provided.
5/28/25 Resident #6 and resident #7 got into a verbal altercation where resident #7 pushed resident #6 in the chest causing [redacted] to fall back and hit [redacted] head resulting in resident #6 being admitted [redacted].
5/28/25 Nursing made both resident #6 and resident #7 POA and PCP aware
5/28/25 Staff redirected resident #7 to [redacted] room
5/28/25 Nurse sent resident #6 to [redacted] Hospital for evaluation.
5/29/25 Connections Manager reported via phone to AAA spoke to [redacted]
5/29/25Connections Manager faxed report to AAA at 1:09pm
5/29/25 Connections Manager emailed State reportable to DHS at 1:06pm
5/29/25 Connections Manager held an educational in service at 10am and 3pm with SDCU staff on behaviors and what to do when residents start having certain behaviors and protocol expectations. Documentation to be provided.
5/29/25 Resident placed resident #7 on UTI protocol and ask PCP for an order for a [redacted] and medication review.
6/2/25 medication changes were made by pcp for resident #7
6/4/25 [redacted] called from protective services to begin investigation and stated [redacted] would not be in touch further
6/11/25 Resident #7 placed on 1:1 services d/t increased behaviors.
6/11/25 Resident #6 Admitted back to SDCU from [redacted].

Campus Executive Director and Connections Manager will have Monthly Educational In services beginning March 17th 2026 for 3 months on abuse and managing behaviors including how to prevent altercations within our SDCU neighborhood.

Connections Manager will continue to have [redacted] monthly behavior huddles with co workers that work in SDCU with the next one being March 12th 2026.

On March 26th the Executive Director of Memory Support will be holding a Managing Behaviors course for all staff. Documentation can be provided.

Licensee's Proposed Overall Completion Date: *03/26/2026*

Implemented ([redacted] - 05/21/2026)

63a - First Aid/CPR Training

5. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On Sunday January 18 into Monday January 19, 2026 from 11:00 PM to 7:00 AM, there were 29 residents in the home, however, no staff who had current training in first aid were present and working in the home.

On Friday January 23 into Saturday January 24, 2026 from 11:00 PM to 7:00 AM, there were 29 residents in the home, however, no staff working overnight in the home had current certification in CPR and first aid.

63a - First Aid/CPR Training (continued)

On Saturday January 24 into Sunday January 25, 2026 from 11:00 PM to 7:00 AM, there were 29 residents in the home, however, no staff working overnight in the home had current certification in CPR and first aid.

Plan of Correction ***Accept (- 03/24/2026)***

Campus Executive Director had educational in-service on February 26th 2026 with Scheduler, Training and Development Coordinator, Executive Director, Assistant Executive Director, Director of Nursing, Assistant Director of Nursing, and Connections Manager on the requirements of having one person per 50 residents that are CPR certified on shift per license building. Documentation will be provided.

Training and Development Coordinator set up 3 classes in March for 3/5/26, 3/17/26, and 3/30/26 to ensure enough CPR/ First Aid trained employees on the 11pm to 7am shift. Documentation can be provided.

Starting March 9th 2026 scheduler will keep a spreadsheet of 11p to 7a coworkers that are CPR/ First Aid certified and ensure they are scheduled in the appropriate licensed building too comply with regulation. Documentation can be provided.

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

Implemented (- 05/21/2026)

82c - Locking Poisonous Materials

6. 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 2/3/26 at 9:25 AM, a cannister of Microkill AF2 disinfectant wipes was unlocked, unattended, and accessible in a cabinet in the home's secured dementia care unit (SDCU) activity room. The cannister was labeled "Call a poison control center or doctor for treatment advice" and "have the product container or label with you when calling poison control center or doctor or going for treatment." None of the residents in the SDCU have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 03/24/2026)***

On 2/3/2026 Campus Executive Director Immediately removed the container of Microkill AF2 disinfectant wipes when found.

On 2/5/2026 Connections Manager had an educational in-service with SDCU staff on policy and procedure surrounding keeping all poisonous materials locked and out of reach of all resident deemed unable to avoid poisonous materials.

Connections Manager will be checking the neighborhood all rooms and common areas for any unlocked poisonous materials once a day for 3 weeks, then once a week for 3 months starting March. 2nd 2026. Documentation to be provided.

82c Locking Poisonous Materials *(continued)*

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

Implemented ([redacted] - 05/21/2026)

91 - Telephone Numbers

7. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in bedroom 306.

Plan of Correction ***Accept ([redacted] - 03/24/2026)***

On February 3rd 2026 phone number sticker was placed on the landline phone in room #6 by Campus Executive Director when it was discovered to be missing.

On February 26th 2026 Campus Executive Director had an educational In service with Connections manager, Executive Director, Associate Executive Director, Director of Nursing, and Assistant Director of Nursing as well as all direct care staff on the importance and policy of all emergency numbers being present in rooms where phones are present for all residents.

Connections Manager will be checking the neighborhood all rooms and common areas for any phones and emergency phone numbers once a day for 3 weeks, then once a week for 3 months starting March. 2nd 2026. Documentation to be provided.

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

Implemented ([redacted] - 05/21/2026)

100b - Removal Snow/Obstructions

8. 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 2/3/26, an accumulation of snow about 6" deep prevented safe access to the electronic keypad at the exit gate of the courtyard.

Plan of Correction ***Accept ([redacted] - 03/24/2026)***

2/3/2026 Campus Executive Director contacted maintenance team to immediate remove the snow in front of the electronic keypad and it was removed same day. Photos provided.

Campus Executive Director had educational in service 2/26/26 on thee process of snow removal and what it looks like on campus to stay in compliance with maintenance team and with Executive Director and Associate Director.

Checklist will need to be completed by maintenance after each significant snow fall to check off that certain areas

100b - Removal Snow/Obstructions (continued)

of the campus have been serviced appropriated and handed to either the Campus Executive Director, Executive Director , or Associate Executive Director for a check off of completion and signature starting 3/1/2026. Documentation to be provided.

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

Implemented ([redacted] - 05/21/2026)

109b - Rabies Vaccination

9. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 2/4/26, a cat belonging to Resident #10 was present in the home. The rabies vaccine for the cat expired 10/12/25.

Plan of Correction ***Accept ([redacted] - 03/24/2026)***

Resident #10 was contacted by front desk receptionist where [redacted] stated the veterinarian could not get the cat in until 2/21/26 . [redacted] missed the last appointment d/t being sick.

On February 21st 2026 resident 10 did get the cat vaccinations up to date. Documentation to be provided.

March 9th 2026 Campus Executive Director will have an educational in-service with front desk receptionist on policy and procedures relating to rabies vaccinations and compliance with this regulation.

Beginning March 9th 2026 the Concierges and receptionist will have a check list in the front of the book where they need to sign that they have looked through and checked the dates of the vaccinations and if anything is out of compliance they have notify the Campus Executive Director for further action to be taken. Documentation will be provided.

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

Implemented ([redacted] - 05/21/2026)

121a - Unobstructed Egress

10. 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 2/3/26 at 9:30 AM, the exit door to the courtyard was locked with a magnetic lock. The keypad used to unlock the door was not operable until a special cylindrical key was inserted into an electronic lock which permitted the operation of the keypad so that the magnetic lock could be disengaged.

On 2/3/26 at 9:30 AM, the swinging exit gate in the courtyard could not be opened because it was frozen in place by snow and ice.

The first, second, and third floor stairwell exit doors are secured with electronic magnetic locks. Only the ground floor

121a - Unobstructed Egress (continued)

of the home is a secured dementia care unit. The stairwell doors could not be opened using the magnetic keypads present at the doors.

Plan of Correction ***Accept (- 03/24/2026)***

On 2/3/26 after speaking to inspector and home office about the lock with the cylindrical key it was unlocked permanently and key was taken by Campus Executive Director. Red Light off. Photos Provided.

On 2/3/26 after inspector pointed out the gate that had opened but gave hesitation d/t ice and snow. Campus Executive Director call maintenance who rectified the situation that day. Photos provided.

On 2/3/26 after inspector pointed out the stairwell door locks Campus Executive Director called our Home Office IT and had them disengaged and unlocked permanently. Documentation provided.

Campus Executive Director had educational in-service 2/26/26 on thee process of snow removal and what it looks like on campus to stay in compliance with maintenance team and with Executive Director and Associate Director.

Campus Executive Director to have an in-service on unobstructed egress on February 26th 2026 with all staff to ensure compliance with this regulation. Documentation to be provided.

Checklist will need to be completed by maintenance after each significant snow fall to check off that certain areas of the campus have been serviced appropriated and handed to either the Campus Executive Director, Executive Director , or Associate Executive Director for a check off of completion and signature starting 3/1/2026. Documentation to be provided

Checklist made by Campus Executive Director for SDCU day shift staff sign off beginning February 9th 2026 to check the cylindrical lock to ensure the red light is not on indicating it is off. It is to be done daily for 3 weeks then one a week for 3 months.

Checklist made by Campus Executive Director to stairwell doors for receptionist or Campus ED to check to ensure all keypads are green meaning not locked daily for 3 weeks the 1 a week for 3 months starting February 9th 2026

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

Implemented (- 05/21/2026)

132a - Monthly Fire Drill

11. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the months of December and July 2025.

Plan of Correction ***Accept (- 03/24/2026)***

Campus Maintenance Director was suspended d/t not performing duties appropriately which included maintaining fire drill logs and procedures which ended in termination.

2/26/26 Campus Executive Director had an educational in-service with all train to trainers on campus on the

132a - Monthly Fire Drill (continued)

expectation and policies and regulations surrounding the expectations of having monthly fire drills with out fail.

Starting February 9, 2026 Campus Executive Director will be transcribing all Fire drills on to DHS form to ensure proper dictation.

February 9th 2026 Campus Executive Director composed Fire Drill Matrix for License 31021 was completed for 2026 to ensure appropriate dates and times per regulations documentation provided.

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

Implemented (- 05/21/2026)

132c - Fire Drill Records

12. 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

During the fire drill on 9/27/25 at 5:15 AM, the home exceeded the maximum safe evacuation time of 13 minutes and 0 seconds as determined by a fire safety expert. The drill required 19 minutes and 58 seconds to evacuate all of the residents, however, there is no documentation of any problems occurring during this drill.

Plan of Correction ***Accept (- 03/24/2026)***

Campus Maintenance Director was suspended d/t not performing duties appropriately which included maintaining fire drill logs and procedures which ended in termination.

Campus executive director had an educational in-service explaining the appropriate procedure for evacuation and the allotted amount of time given 13 mins, as well as the importance of repeating a failed fire drill on 2/26/26. Documentation provided.

Starting February 9, 2026 Campus Executive Director will be transcribing all Fire drills on to DHS form to ensure proper dictation.

February 9th 2026 Campus Executive Director composed Fire Drill Matrix for License 31021 was completed for 2026 to ensure appropriate dates and times per regulations documentation provided.

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

Implemented (- 05/21/2026)

132d - Evacuation

13. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

132d - Evacuation *(continued)*

Description of Violation

During the fire drill on 9/27/25 at 5:15 AM, the home exceeded the maximum safe evacuation time of 13 minutes and 0 seconds as determined by a fire safety expert. The drill required 19 minutes and 58 seconds to evacuate all of the residents.

Plan of Correction ***Accept (- 03/24/2026)***

Campus Maintenance Director was suspended d/t not performing duties appropriately which included maintaining fire drill logs and procedures which ended in termination.

Campus executive director had an educational in-service explaining the appropriate procedure for evacuation and the allotted amount of time given 13 mins, as well as the importance of repeating a failed fire drill on 2/26/26. Documentation provided.

Starting February 9, 2026 Campus Executive Director will be transcribing all Fire drills on to DHS form to ensure proper dictation.

February 9th 2026 Campus Executive Director composed Fire Drill Matrix for License 31021 was completed for 2026 to ensure appropriate dates and times per regulations documentation provided.

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

Implemented (- 05/21/2026)

132e - Fire Drill Sleeping Hours

14. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 9/27/25 at 5:15 AM. The previous fire drill conducted during sleeping hours occurred on 3/12/25 at 2:34 AM.

Plan of Correction ***Accept (- 03/24/2026)***

Campus Maintenance Director was suspended d/t not performing duties appropriately which included maintaining fire drill logs and procedures which ended in termination.

On February 26 2026 Campus Executive Director had educational In-service outlining the policy on fire drills occurring during sleeping hours and how they must occur not just at 6 months but including the date . Documentation provided . (However the date on this violation is within 6 months)

Starting February 9, 2026 Campus Executive Director will be transcribing all Fire drills on to DHS form to ensure proper dictation.

February 9th 2026 Campus Executive Director composed Fire Drill Matrix for License 31021 was completed for 2026 to ensure appropriate dates and times per regulations documentation provided.

132e - Fire Drill Sleeping Hours *(continued)*

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

Implemented ([redacted] - 05/21/2026)

183d - Prescription Current

15. 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

A bottle of Lisinopril – HCTZ 20 – 12.5mg belonging to Resident #3 was present in the medication cart, however, this medication was discontinued on 12/15/25.

Plan of Correction ***Accept ([redacted] - 03/24/2026)***

On February 4th 2026 when bottle was founded by inspector . Medication associate and Director of Nursing removed the bottle of Lisinopril-HCTZ 20-12.5MG belonging too resident #3 that was discontinued.

On March 6 2026 Assistant Director of Nursing had educational in-service with medication associates and nurses on regulation concerning current prescriptions and removal of discontinued medications on the medication carts. Documentation to be provided.

Director of Nursing and Assistant Director of Nursing will do medication cart audit once a week starting March 9th 2026 for 3 weeks then once month for 3 months there after to ensure no discontinued medications are on the cart. Documentation to be provided.

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

Implemented ([redacted] - 05/21/2026)

184b - Labeling OTC/CAM

16. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

A 300-count bottle of Women's One-A-Day vitamins belonging to Resident #8 was in the medication cart and was not labeled with the resident's name. A bottle of Calcium Tablets, 600 MG, belonging to Resident #9 was in the medication cart and was not labeled with the resident's name.

Plan of Correction ***Accept ([redacted] - 03/24/2026)***

On February 4th 2026 when inspector found the vitamins for resident #8 and resident #9 on the cart without proper labels. Medication associate and Director of Nursing removed the medications and printed proper labels to place on the bottles immediately.

On March 6 2026 Assistant Director of Nursing had educational in-service with medication associates and nurses on regulation concerning the labeling of OTC/CAM medications and the importance of ensuring this is done prior to placing medications into the medication cart. Documentation to be provided.

184b Labeling OTC/CAM (continued)

Director of Nursing and Assistant Director of Nursing will do medication cart audit once a week starting March 9th 2026 for 3 weeks then once month for 3 months there after to ensure no unlabeled OTC/ CAM medications are on the cart. Documentation to be provided.

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

Implemented (- 05/21/2026)

227c - Support Plan Revision

17. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #3's current support plan, completed , and updated indicates that the resident's family is working on obtaining 1:1 supervision. These services were obtained through the use of a private pay agency on , however were not included in an update to the support plan.

Plan of Correction ***Accept (- 03/24/2026)***

On February 4 2026 an addendum to RASP was done for resident #3 with the date 1:1 was implemented by family and then one for when it was implemented by senior helpers. Documentation to be provided.

On resident #3 discharged from Ecumenical to

On February 26 2026 Campus Executive Director had an in service with building managers including Executive Director, Associate Executive Director, Connections Manager, Director of Nursing, Assistant Director of Nursing to go over Support Plan Revisions and what kind of information is necessary to place in a revision. Documentation to be provided.

Connections Manager and Campus Executive Director will begin to Audit Resident Assessment Support Plans on March 9th to ensure all addendums have been added for all necessary changes. Documentation to be provided.

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

Implemented (- 05/21/2026)