

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

June 15, 2026

[REDACTED], ADMINISTRATOR  
HILLSIDE REST HOME, INC.  
[REDACTED]

RE: HILLSIDE PERSONAL CARE  
1175 OLD WAYNESBORO PIKE  
FAIRFIELD, PA, 17320  
LICENSE/COC#: 34875

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/11/2026, 02/12/2026 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: *HILLSIDE PERSONAL CARE* License #: *34875* License Expiration: *04/17/2026*  
 Address: *1175 OLD WAYNESBORO PIKE, FAIRFIELD, PA 17320*  
 County: *ADAMS* Region: *CENTRAL*

**Administrator**

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

**Legal Entity**

Name: *HILLSIDE REST HOME, INC.*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *12/08/1978* Issued By: *Labor and Industry*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *35* Waking Staff: *26*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal, Complaint* Exit Conference Date: *02/12/2026*

**Inspection Dates and Department Representative**

02/11/2026 - On-Site: [REDACTED]  
 02/12/2026 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: *48* Residents Served: *35*

Secured Dementia Care Unit  
 In Home: *No* Area: Capacity: Residents Served:

Hospice  
 Current Residents: *0*

Number of Residents Who:  
 Receive Supplemental Security Income: *8* Are 60 Years of Age or Older: *35*  
 Diagnosed with Mental Illness: *30* Diagnosed with Intellectual Disability: *12*  
 Have Mobility Need: *0* Have Physical Disability: *0*

**Inspections / Reviews**

02/11/2026 Full  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/09/2026*

03/16/2026 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: *04/13/2026*  
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/23/2026*

Inspections / Reviews *(continued)*

03/24/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/13/2026

Reviewer: [REDACTED]

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

06/15/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/13/2026

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 2/5/26 at 2:45 PM, Resident #1 walked behind Resident #2 and swung [redacted] wooden cross necklace (approximately 3") striking Resident #2 on the top of [redacted] head. Staff evaluated Resident #2. There were no visible injuries, but an ice pack was applied to the area. Resident #2 requested police be called. The police did come and took a report of the incident. The home did not report this incident to the local Area Agency on Aging until 2/9/26 at 2:00 PM.

Plan of Correction

Accept ([redacted] - 03/24/2026)

Immediate Corrective Action

The 2/5/26 incident involving Resident #1 and Resident #2 was reported to the local Area Agency on Aging and to the Department on 2/9/26. Upon receipt of the violation, the Administrator immediately reviewed mandatory reporting timeframes with all supervisory staff on 2/12/26.

All incident reports from 11/1/25–2/11/26 were audited on 2/13/26 to ensure timely reporting to AAA and DHS. No additional late reports were identified.

Systemic Changes

- Revised Abuse Reporting Policy to include a 24-hour reporting checklist, implemented 2/15/26 to be completed by the Administrator or Supervisor Designee.
- Administrator implemented an Incident Reporting Log with submission date/time tracking started on 2/15/26
- Mandatory abuse reporting in-service conducted 2/14/26 (attendance maintained).
- A secondary on-call reporting designee will be available 24/7 to ensure no delay in AAA/DHS reporting when the Administrator is off-site started on 2/15/26
- Incident timeliness will be tracked on a monthly QA binder and reviewed at the quarterly QA meetings, started on 3/10/26. Administrator will review the binder and advise as needed.

Monitoring

Administrator will review all incident reports weekly for 90 days to ensure reporting within required timeframe and document compliance in the QA binder. After 90 days, incident reporting will be reviewed monthly as part of the facility's QA program.

Completion Date: 2/14/26

Responsible Person: Administrator

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented ([redacted] - 06/15/2026)

## 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 2/5/26 at 2:45 PM, Resident #1 walked behind Resident #2 and swung [REDACTED] wooden cross necklace (approximately 3") striking Resident #2 on the top of [REDACTED] head. Staff evaluated Resident #2. There were no visible injuries, but an ice pack was applied to the area. Resident #2 requested police be called. The police did come and took a report of the incident. The home did not report this incident to the Department until 2/9/26 at 2:00 PM.

### Plan of Correction

Accept ([REDACTED] - 03/24/2026)

#### Immediate Corrective Action

The 2/5/26 incident involving Resident #1 and Resident #2 was reported to the local Area Agency on Aging and to the Department on 2/9/26. Upon receipt of the violation, the Administrator immediately reviewed mandatory reporting timeframes with all supervisory staff on 2/12/26.

All incident reports from 11/1/25–2/11/26 were audited on 2/13/26 to ensure timely reporting to AAA and DHS. No additional late reports were identified.

#### Systemic Changes

- Revised Abuse Reporting Policy to include a 24-hour reporting checklist, implemented 2/15/26 to be completed by the Administrator or Supervisor Designee.
- Administrator implemented an Incident Reporting Log with submission date/time tracking started on 2/15/26
- Mandatory abuse reporting in-service conducted 2/14/26 (attendance maintained).
- A secondary on-call reporting designee will be available 24/7 to ensure no delay in AAA/DHS reporting when the Administrator is off-site started on 2/15/26
- Incident timeliness will be tracked on a monthly QA binder and reviewed at the quarterly QA meetings, started on 3/10/26. Administrator will review the binder and advise as needed.

#### Monitoring

**16c Written Incident Report (continued)**

Administrator will review all incident reports weekly for 90 days to ensure reporting within required timeframe and document compliance in the QA binder. After 90 days, incident reporting will be reviewed monthly as part of the facility's QA program.

Completion Date: 2/14/26

Responsible Person: Administrator

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented (█) - 06/15/2026)

**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**

On 2/5/26 at 2:45 PM, Resident #1 walked behind Resident #2 and swung █ wooden cross necklace (approximately 3") striking Resident #2 on the top of █ head. Staff evaluated Resident #2. There were no visible injuries, but an ice pack was applied to the area. Resident #2 requested police be called. The police did come and take a report of the incident.

Residents #2, #7, #8, #9 and #10 reported they have witnessed Staff Members A and B yell at Residents #1 and #6. Resident #2 reported Staff Member B gets overwhelmed, curses and yells at Resident #6. Resident #7 reported Staff Members A and B are not kind to Residents #1 and #6. Resident #7 stated Staff Members A and B yell and curse at Residents #1 and #6. Resident #7 reported on 2/10/26, Staff Member B pushed Resident #6 and yelled at Resident #6 to "Sit the hell down!" Resident #10 reported Staff Member A yells daily. Resident #10 also stated that even though Staff Member A has been told the resident cannot have carbohydrates, Staff Member A continues to give the resident bread.

Resident #8 stated Staff Member A is short tempered and yells "Sit down!" or "Sit the hell down!", specifically to Resident #6 and #11. Resident #8 reported Staff Member B pushed Resident #6 from the med cart to the middle of the room until █ sat down. Resident #8 described the pushing as shoving several times to get Resident #6 away from the medication cart. Resident #8 reported Staff Members A and B yell at Resident #1. Resident #8 said Staff Member B curses at Resident #1 and has heard Staff Member B say, "God damnit, sit down, I'm not telling you again!" Resident #8 reported Staff Member B has also pushed Resident #1 to go sit down.

Resident #9 reported Staff Member A yells, and Staff Member B yells and curses at residents. Resident #9 has witnessed Staff Member B push Resident #6 back to █ seat with several forceful nudges. Resident #10 reported Staff Person A yells at residents, sometimes it is "an everyday thing."

## 42b Abuse (continued)

**Plan of Correction**

Accept (█) - 03/24/2026)

*Immediate Corrective Action*

The home acknowledges the seriousness of the allegations and has taken immediate action to protect all residents. Staff Members A and B were immediately suspended pending investigation on 2/11/26. Staff member A resigned on █. Staff Member B had direct supervision while on duty from supervisory staff from 2/12/26 thru 2/28/26. Starting on 3/1/26 thru 3/10/26 direct supervision was during medication passes. Starting 3/11/26 direct supervision is random one time per Staff B's shift. All other shifts have increased supervision to random checks once per shift by Supervisory Staff. Staff Member B received the below training by the Administrator on 2/13/26. Residents #1, #6, #11 and others were assessed for injury and emotional well being. Support plans for Residents #1, #6, and #11 were updated on 2/17/26 to address triggers, supervision, and communication strategies. Protective measures implemented including supervision and resident interviews.

All residents were interviewed privately by administration on 2/12/26. Care plans were reviewed for behavioral triggers and supervision needs.

*Systemic Changes*

- Zero tolerance abuse policy reissued and signed by all staff from 2/12/26 thru 2/17/26 by Administrator and Office Manager.
- All staff will complete quarterly refresher training in trauma informed care and resident rights for the next 12 months starting in February 2026.
- De escalation and dementia care training completed 2/18/26 by Administrator & Office Manager with all staff.
- Increased supervisory presence on all shifts. Supervisors will conduct two unannounced walk throughs per first and second shift and one during third shift for 60 days, documented on the Abuse Prevention Oversight Log starting on 2/13/26. During walk through the supervisor will observe staff and resident interactions.
- On 2/13/26 the Administrator established an anonymous reporting mechanism for residents/staff.

*Monitoring*

Administrator/designee will conduct random weekly resident interviews for 8 weeks and document findings in QA log starting 2/13/26. Resident interviews will be done monthly by Supervisor Staff to ensure they feel safe and supported.

Responsible Person: Administrator

Completion date 2/18/26

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented (█) - 06/15/2026)

## 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 D, hired on [REDACTED] indicated on their application that they had not lived in the state of Pennsylvania for two years prior to application. However, an FBI background check was not completed. In addition, Staff Member D did not have a Pennsylvania State Police criminal background check completed until [REDACTED]

Staff Person G, hired on [REDACTED] did not have a Pennsylvania State Police criminal background check completed until [REDACTED]

**Plan of Correction**

Accept ([REDACTED] - 03/24/2026)

*Immediate Corrective Action*

Staff persons D and G files were reviewed on 2/13/26. Staff person D hired [REDACTED] and Pennsylvania State Police criminal background check was done on [REDACTED] within the required 30 days. Staff person D had an FBI clearance completed on [REDACTED]

Staff person G hired on [REDACTED] with the Pennsylvania State Police background check being completed on [REDACTED] within the required 30 days.

Personnel files of all active staff audited 2/13/26. Deficiencies corrected immediately.

These actions corrected the deficient practice.

*Systemic Changes*

- Hiring checklist revised on 2/13/26 to require the Pennsylvania State Police background check to be initiated prior to employees first day of works and the FBI background check scheduled prior to employees first day of work by the Administrator
- No employee permitted to work until all clearances are scheduled.
- Administrator and New Hire Trainer will jointly sign off each new hire file before scheduling starting on 2/13/26
- Quarterly audits will include a random sample of 25% of personnel files started on 2/13/26

*Monitoring*

Administrator will audit 100% of new hire files prior to scheduling and quarterly audits will include a random sample of 25% of personnel files thereafter. No staff will be permitted to begin orientation or shadowing until all required FBI clearances are scheduled as required and Pennsylvania State background check filed as required starting on 2/13/26

HR and the Administrator will jointly sign off on each new hire file before scheduling starting on 2/13/26

Administrator provided training to Office Manager on 2/13/26

51 Criminal Background Check (continued)

Completion Date: 2/13/26

Responsible Person: Administrator

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented (█) - 06/15/2026)

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

From 1/25/26 through 2/4/26, there were 33 residents present in the home. However, on the following dates and times, there were no staff present in the home who were certified in First Aid and CPR:

- 1/25/26 11:00 PM 1/26/25 7:00 AM
- 1/26/26 3:00 PM 1/27/26 7:00 AM
- 1/27/26 11:00 PM 1/28/26 6:00 AM
- 1/28/26 3:00 PM 1/29/26 7:00 AM
- 1/29/26 8:00 PM 1/30/26 6:00 AM
- 1/30/26 3:00 PM 1/31/26 7:00 AM
- 1/31/26 11:00 PM 2/1/26 7:00 AM
- 2/1/26 9:00 PM 2/2/26 6:00 AM
- 2/2/26 3:00 PM 2/3/26 7:00 AM
- 2/3/26 11:00 PM 2/4/26 7:00 AM

From 2/4/26 through 2/7/26, there were 34 residents in the home. However, on the following dates and times, there were no staff present in the home who were certified in First Aid and CPR:

- 2/4/26 3:00 PM 2/5/26 7:00 AM
- 2/5/26 10:00 PM 2/6/26 6:00 AM
- 2/6/26 3:00 PM 2/7/26 7:00 AM
- 2/7/26 11:00 PM 2/8/26 7:00 AM

Plan of Correction

Accept (█) - 03/24/2026)

Immediate Corrective Action

CPR/First Aid trainer completed their recertification to train on 2/25/2026.

Staff person B, E, F, H, I retraining's were completed 2/26/26 through 3/6/26. CPR/First Aid cards were issued on 3/6/2026.

Systemic Changes

63a - First Aid/CPR Training (continued)

Trainer will provide staff scheduler monthly with a spreadsheet of CPR/First Aid certifications. Trainer will schedule and complete recertifications prior to their expiration. Trainer will use an electronic reminder system for certifications.

The scheduler will use a CPR/First Aid coverage grid: any shift lacking a CPR/First Aid certified staff will be flagged and corrected before posting the schedule.

Administrator will review the CPR/First Aid Coverage Grid weekly for 6 months and document compliance in the QA binder. After 6 months, CPR/First Aid coverage will be reviewed monthly.

Administrator educated the Medical Care Coordinator about regulation on 3/16/26

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented (████) - 06/15/2026

65e - 12 Hours Annual Training

6. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Staff Member E, hired on █████ received only 9 hours of annual training in training year 1/16/25 - 1/15/26.

Plan of Correction

Accept (████) - 03/24/2026

Immediate Corrective Action

Staff person E completed additional 3 hours of required training including dementia care on 2/17/26.

All staff training records audited 2/14/26 by Office Manager. Any deficits corrected.

Systemic Changes

- Training tracking spreadsheet implemented on 2/18/26 by Office Manager.
- Automatic reminder 60 days prior to training anniversary.
- Staff will not be scheduled beyond 30 days of their training anniversary without verification of completed hours.

Monitoring

The Administrator will receive a spreadsheet from HR of training anniversaries with alerts 30 and 15 days before any staff training deadline highlighted.

Quarterly training audit by Administrator. Training topics will be reviewed quarterly during the QA meeting to ensure alignment with resident needs and regulatory requirements started 2/18/26

Training audits and reminder logs will be maintained in the Training Compliance Binder.

65e - 12 Hours Annual Training (continued)

Administrator educated Office Manager on 2/18/26 about the regulation.

Completion Date: 2/17/26

Responsible Person: Administrator / Employee Trainer

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented (█) - 06/15/2026)

65f - Training Topics

7. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 3. Care for residents with dementia and cognitive impairments.

Description of Violation

Staff Member E, hired on █ did not receive training in care for residents with dementia and cognitive impairments during training year 1/16/25 - 1/15/26.

Plan of Correction

Accept (█) - 03/24/2026)

Immediate Corrective Action

Staff person E completed additional 3 hours of required training including dementia care on 2/17/26.

All staff training records audited 2/14/26 by Office Manager. Any deficits corrected.

Systemic Changes

- Training tracking spreadsheet implemented on 2/18/26 by Office Manager.
- Automatic reminder 60 days prior to training anniversary.
- Staff will not be scheduled beyond 30 days of their training anniversary without verification of completed hours.

Monitoring

The Administrator will receive a spreadsheet from HR of training anniversaries with alerts 30 and 15 days before any staff training deadline highlighted.

Quarterly training audit by Administrator. Training topics will be reviewed quarterly during the QA meeting to ensure alignment with resident needs and regulatory requirements started 2/18/26

Training audits and reminder logs will be maintained in the Training Compliance Binder.

65f - Training Topics (continued)

Administrator educated Office Manager on 2/18/26 about the regulation.

Completion Date: 2/17/26

Responsible Person: Administrator / Employee Trainer Immediate Corrective Action

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented (█) - 06/15/2026

85a - Sanitary Conditions

8. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/11/26 at approximately 9:50 AM, bathrooms #3, #4 and #5 had a strong smell of urine. Bathroom #5 had splatters of feces stuck on the inside of the toilet.

On 2/11/26, Resident #3's room contained a significant amount of mouse droppings including at the head and foot of the resident's bed, behind the folding chairs and other items.

Plan of Correction

Accept (█) - 03/24/2026

Immediate Corrective Action

All Bathrooms cleaned and sanitized 2/11/26 by Housekeeping

The mouse droppings in Room #3 were cleaned up on 2/11/26 by Housekeeping.

Administrator educated Housekeeping Supervisor on this regulation on 2/17/26

Professional exterminator contracted 10/27/2025; treatments completed 10/27/25, 11/14/25, 12/12/25, 1/30/26, 2/2/26, 2/25/26 monthly on-going

Recycling/trash secured in covered receptacles.

All resident rooms inspected for any food storage and excessive clutter on 2/12/26.

Systemic Changes

- Added daily bathroom/environmental sanitation checklist and will be verified by a supervisor starting on 2/20/26
- Monthly pest control contract established.
- Maintenance assigned weekly exterior trash inspection starting on 2/20/26

85a - Sanitary Conditions (continued)

Monitoring

Housekeeping staff will complete a daily sanitation checklist that must be signed by a supervisor.

Environmental rounds will include odor checks, fixture inspections, and sanitation verification. The Administrator will verify completion three times weekly for 90 days, then monthly.

Administrator or housekeeping supervisor will keep a record of the weekly environmental rounds for 90 days starting on 2/13/26

Any evidence of pests will trigger an immediate same-day call to the exterminator.

Monthly pest control treatments are ongoing and documented in the Pest Control Log by the Building Manager

Completion Date: 2/13/26

Responsible Person: Administrator / Maintenance Supervisor

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented ( ) - 06/15/2026

85b - Infestation

9. Requirements

2600.

85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 2/11/26, Resident #3's room contained a significant amount of mouse droppings including at the head and foot of the resident's bed, behind the folding chairs and other items.

Plan of Correction

Accept ( ) - 03/24/2026

Immediate Corrective Action

All Bathrooms cleaned and sanitized 2/11/26 by Housekeeping

The mouse droppings in Room #3 were cleaned up on 2/11/26 by Housekeeping.

Administrator educated Housekeeping Supervisor on this regulation on 2/17/26

Professional exterminator contracted 10/27/2025; treatments completed 10/27/25, 11/14/25, 12/12/25, 1/30/26, 2/2/26, 2/25/26 monthly on-going

Recycling/trash secured in covered receptacles.

All resident rooms inspected for any food storage and excessive clutter on 2/12/26.

Systemic Changes

**85b Infestation (continued)**

- Added daily bathroom/environmental sanitation checklist and will be verified by a supervisor starting on 2/20/26
- Monthly pest control contract established.
- Maintenance assigned weekly exterior trash inspection starting on 2/20/26

*Monitoring*

*Housekeeping staff will complete a daily sanitation checklist that must be signed by a supervisor.*

*Environmental rounds will include odor checks, fixture inspections, and sanitation verification. The Administrator will verify completion three times weekly for 90 days, then monthly.*

*Administrator or housekeeping supervisor will keep a record of the weekly environmental rounds for 90 days starting on 2/13/26*

*Any evidence of pests will trigger an immediate same day call to the exterminator.*

*Monthly pest control treatments are ongoing and documented in the Pest Control Log by the Building Manager*

*Completion Date: 2/13/26*

*Responsible Person: Administrator / Maintenance Supervisor*

**Licensee's Proposed Overall Completion Date: 03/25/2026**

**Implemented (█ - 06/15/2026)**

**85e - Trash Outside Home**

**10. Requirements**

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

**Description of Violation**

*On 2/11/26 at approximately 10:00 AM, the outside recycling bins were overflowing and the lids were open.*

**Plan of Correction**

**Accept (█ - 03/24/2026)**

*Immediate Corrective Action*

*All Bathrooms cleaned and sanitized 2/11/26 by Housekeeping*

*The mouse droppings in Room #3 were cleaned up on 2/11/26 by Housekeeping.*

**85e - Trash Outside Home (continued)**

*Administrator educated Housekeeping Supervisor on this regulation on 2/17/26*

*Professional exterminator contracted 10/27/2025; treatments completed 10/27/25, 11/14/25, 12/12/25, 1/30/26, 2/2/26, 2/25/26 monthly on-going*

*Recycling/trash secured in covered receptacles.*

*All resident rooms inspected for any food storage and excessive clutter on 2/12/26.*

*Maintenance Supervisor educated the maintenance staff on 2/13/26 on this regulation*

### *Systemic Changes*

- Added daily bathroom/environmental sanitation checklist and will be verified by a supervisor starting on 2/20/26*
- Monthly pest control contract established.*
- Maintenance assigned weekly exterior trash inspection starting on 2/20/26*

*If recycles are overflowing, they will be placed in the regular trash dumpster by maintenance, this was completed on 2/11/26*

### *Monitoring*

*Housekeeping staff will complete a daily sanitation checklist that must be signed by a supervisor.*

*Environmental rounds will include odor checks, fixture inspections, and sanitation verification. The Administrator will verify completion three times weekly for 90 days, then monthly.*

*Administrator or housekeeping supervisor will keep a record of the weekly environmental rounds for 90 days starting on 2/13/26*

*Any evidence of pests will trigger an immediate same-day call to the exterminator.*

*Monthly pest control treatments are ongoing and documented in the Pest Control Log by the Building Manager*

*Completion Date: 2/13/26*

85e *Trash Outside Home (continued)*

*Responsible Person: Administrator / Maintenance Supervisor*

**Licensee's Proposed Overall Completion Date: 03/25/2026**

**Implemented (█ - 06/15/2026)**

88a - Surfaces

**11. Requirements**

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

**Description of Violation**

*On 2/11/26 at approximately 10:00 AM, there was a hole in the wall beside the fire alarm on the first floor.*

*Bathroom #3's door had an approximate 2 foot crack on the front and the wood was pushed in near the door handle.*

*The left lower side of the window located in the dining room had an approximately 2 foot by 1 foot piece of the wall that has blistering peeling paint, water stains, and a crack underneath the expander guard of the window air conditioning unit installed in the window.*

*In the bathroom on the first floor located near the laundry room the floor slopes toward the bathtub. The linoleum is coming up on the right side of the door as you exit the bathroom. The linoleum in this area near the door is buckled up approximately 12 inches by 4 inches. The slopping floor and raised linoleum poses a tripping hazard.*

**Plan of Correction**

**Accept (█ - 03/24/2026)**

*Immediate Corrective Action*

*The following to be completed by Maintenance:*

*Hole in wall to be repaired by 3/20/26.*

*Bathroom door to be replaced by 3/20/26.*

*Dining room wall to be repaired and repainted by 3/20/26.*

*Bathroom flooring to be repaired and secured by 4/10/26*

*Full building safety inspection conducted 2/28/26 by Building Supervisor*

*Systemic Changes*

- Maintenance will complete a monthly building wide structural integrity checklist starting on 3/1/26*
- Any identified hazard will be corrected within 48 hours unless a contractor is required by Maintenance*
- All repairs will be logged with priority levels assigned (urgent 24 hours, high 72 hours, routine 7 days) as well as with date, time, and responsible staff.*

*Maintenance Supervisor educated the maintenance staff on 2/13/26 on this regulation*

*Monitoring*

*Maintenance log reviewed monthly by Maintenance Supervisor starting on 3/1/26*

*Completion Date: 3/20/26*

88a Surfaces (continued)

Responsible Person: Maintenance / Administrator

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

Implemented ( ) - 06/15/2026

123c - Evacuation Diagrams

12. Requirements

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 35 residents. However, there are no emergency evacuation diagram posted in the home.

Plan of Correction

Accept ( ) - 03/24/2026

Immediate Corrective Action

Evacuation diagrams created and posted on each floor on 2/15/26 by the Building Supervisor.

Systemic Changes

Evacuation diagrams will be reviewed and documentation kept during monthly fire drills to ensure accuracy by Building Supervisor starting on 3/1/26

Diagrams will be laminated and mounted at eye level in high traffic areas by the Building Supervisor.

Administrator educated the Building Manager on 2/13/26 on this regulation

Monitoring

Quarterly safety walk through by the Building Supervisor starting on 3/1/26

Completion Date: 2/15/26

Responsible Person: Administrator

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented ( ) - 06/15/2026

141b1 - Annual Medical Evaluation

13. Requirements

2600.

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

Description of Violation

Resident 12's most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted]

Resident #13's most recent medical evaluation was completed on [redacted]

Plan of Correction

Accept ( ) - 03/24/2026

Immediate Corrective Action

141b1 Annual Medical Evaluation (continued)

Resident #12 and #13 physician appointments scheduled; updated evaluations obtained 2/17/26 by Medical Care Coordinator

100% audit of medical evaluations completed 2/12/26. by Medical Care Coordinator

Systemic Changes

Medical Evaluation Tracking Log implemented by Medical Care Coordinator started on 2/17/26

Medical evaluations will be scheduled 30 days before the due date to prevent lapses if appointments are canceled, rescheduling will occur within 48 hours.

Education provider to the Medical Care Coordinator by Administrator on 2/17/26

Monitoring

Monthly audit of due dates by Administrator starting on 2/17/26

Completion Date: 2/17/26

Responsible Person: Administrator/Medical Care Coordinator

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented (█) - 06/15/2026

144c1 - Smoking Area Guidelines

14. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area is under the port outside of the home. On 2/11/26, there were over 30 cigarette butts on the ground surrounding the smoking area.

Plan of Correction

Accept (█) - 03/24/2026

Immediate Corrective Action

Smoking area cleaned 2/11/26 by Maintenance Staff

Systemic Changes

Housekeeping Staff assigned daily smoking area inspection and documented in the Housekeeping Log starting on 3/1/26

Staff educated by Administrator to alert visitors of proper receptacle for cigarette butts on 2/13/26.

Building Supervisor spoke with transportation company about educating their drivers of the Smoking Policy at the home on 3/12/26

Monitoring

Daily smoking area checklist will be reviewed daily by the Building Supervisor for two months, then weekly

144c1 - Smoking Area Guidelines (continued)

thereafter starting on 3/1/26

Completion Date: 2/13/26

Responsible Person: Maintenance

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented ( ) - 06/15/2026

182b - Prescription Medication

15. Requirements

2600.

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

- 4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 1/3/26 and 1/24/26 at 9:00 PM, Staff Member H administered Trulicity 0.75 MG./0.5 ML Pen to Resident #12. However, Staff Person H has not completed the required training to be able to administer subcutaneous GLP-1 agonist medications

On 1/10/26 at 9:00 PM, Staff Member C administered Trulicity 0.75 MG/0.5 ML Pen to Resident #12. However, Staff Person C has not completed the required training to be able to administer subcutaneous GLP-1 agonist medications

Plan of Correction

Directed ( ) - 03/24/2026

Immediate Corrective Action

Doctors were contacted on 3/17/26 to schedule self-medicating resident(s) education of proper techniques and ability to self-administer GLP-1 medications

A request for waiver from DHS will be applied for by 3/18/26

Medication administration records audited 2/12/26; no adverse outcomes identified.

Systemic Changes

Medication competency verification checklist implemented by Medication Trainer

Monitoring

Quarterly MAR audit for 6 months by Medication Administrators

Responsible Person: Administrator

[Directed]

- In addition to the above steps, GLP-1 medications will be administered by a licensed medical professional until either the resident(s) are assessed as being able to self-administer their GLP-1 medications or the DHS waiver is approved, and the home is in compliance with the outlined requirements in the waiver.
- All med techs and the Medication Training will be educated on regulation 2600.182(b)4 by 4/10/26. Documentation of this education will be kept and available for review by the Department.

182b - Prescription Medication (continued)

Directed Completion Date: 04/10/2026

Implemented ( ) - 06/15/2026

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 2/11/26 at approximately 9:45 AM, the home's medication cart was unlocked, unattended, and accessible in the dining room and included the medications for all of the residents.

Plan of Correction

Accept ( ) - 03/24/2026

Immediate Corrective Action

Staff re-educated 2/11/26 by the Medication Trainer

Medication cart secured immediately on 2/11/26 by the Medication Technician

Discontinued medication removed and destroyed per policy 2/12/26 by the Medication Technician

Full med cart audit completed 2/12/26 by Medical Care Coordinator

Systemic Changes

Shift-to-shift narcotic and cart lock verification log implemented by Medication Trainer on 3/18/26 and to be completed by the Medication Technician

Monitoring

Weekly medication cart audit for security protocol and removal of discontinued medications for 90 days by Administrator, Medical Care Coordinator, or Building Manager started on 2/12/26 and will be documented in the Medication QA binder.

Completion Date: 2/12/26

Responsible Person: Administrator / Medical Care Coordinator / Building Manager / Medication Technicians

Licensee's Proposed Overall Completion Date: 03/25/2026

Implemented ( ) - 06/15/2026

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 2/12/26, Systane Complete Dry Eye Relief prescribed to Resident #12 was located in the medication cart.

**183d Prescription Current (continued)**

However, this medication was discontinued on 1/23/26

**Plan of Correction****Accept ( [REDACTED] - 03/24/2026)***Immediate Corrective Action*

Staff re educated 2/11/26 by the Medication Trainer

Medication cart secured immediately on 2/11/26 by the Medication Technician

Discontinued medication removed and destroyed per policy 2/12/26 by the Medication Technician

Full med cart audit completed 2/12/26 by Medical Care Coordinator

*Systemic Changes*

Shift to shift narcotic and cart lock verification log implemented by Medication Trainer on 3/18/26 and to be completed by the Medication Technician

*Monitoring*

Weekly medication cart audit for security protocol and removal of discontinued medications for 90 days by Administrator, Medical Care Coordinator, or Building Manager started on 2/12/26 and will be documented in the Medication QA binder.

Completion Date: 2/12/26

Responsible Person: Administrator / Medical Care Coordinator / Building Manager / Medication Technicians

**Licensee's Proposed Overall Completion Date: 03/25/2026**

**Implemented ( [REDACTED] - 06/15/2026)**