

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

September 16, 2026

[REDACTED]
COLUMBIA COTTAGE-HERSHEY LLC
[REDACTED]
[REDACTED]

RE: COLUMBIA COTTAGE-HERSHEY, LLC
103 N. LARKSPUR DRIVE
PALMYRA, PA, 17078
LICENSE/COC#: 33024

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/13/2026, 02/17/2026, 03/02/2026, 03/03/2026, 03/13/2026, 03/30/2026, 04/27/2026 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]
ashambach@pa.gov

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: COLUMBIA COTTAGE-HERSHEY, LLC

License #: 33024

License Expiration: 05/02/2026

Address: 103 N. LARKSPUR DRIVE, PALMYRA, PA 17078

County: LEBANON

Region: CENTRAL

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: COLUMBIA COTTAGE-HERSHEY LLC

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 55

Waking Staff: 41

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Complaint

Exit Conference Date: 04/29/2026

Inspection Dates and Department Representative

02/13/2026 - On-Site: [REDACTED]

02/17/2026 - Off-Site: [REDACTED]

03/02/2026 - Off-Site: [REDACTED]

03/03/2026 - Off-Site: [REDACTED]

03/13/2026 - Off-Site: [REDACTED]

03/30/2026 - Off-Site: [REDACTED]

04/27/2026 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 60

Residents Served: 34

Special Care Unit

In Residence: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 3

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 34

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 21

Have Physical Disability: 0

Inspections / Reviews

02/13/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 05/16/2026

06/03/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/10/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 06/10/2026

09/16/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/10/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a Resident abuse report**1. Requirements**

2800.

15.a. The residence shall immediately report suspected abuse of a resident served in the residence 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, neglect, abandonment or exploitation) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [REDACTED], between 5:30pm-8:30pm, Staff member A heard Staff member B yelling at Resident [REDACTED] saying, [REDACTED] not here to be a slave to {Resident [REDACTED] has put {Resident [REDACTED] in bed and that is where you are expected to stay, I am not getting you up and down all night, that is not my job, I am done caring for you, that is not my problem," mixed with vulgar language and using profanities. Staff member A reports the yelling was "unprofessional and not acceptable by any means." Staff member A observed Staff member B continue to yell at the resident for 3-5 minutes instead of assisting the resident, when the resident, who required 2-person assist, was partially hanging off their bed. Staff member A reports Resident [REDACTED] was visibly upset, shaking, and expressing concerns about the treatment [REDACTED] had received in the facility. This incident was observed by Staff members C and D and the home's management was also immediately contacted. However, this allegation of abuse was not verbally reported to the local Area Agency on Aging until [REDACTED] at 10:20am.

Plan of Correction

Accept [REDACTED] 06/03/2026)

Immediate Corrective Action

The allegation of abuse was verbally reported to the local Area Agency on Aging on 01/08/2026.

The staff member involved was immediately removed from resident care responsibilities and is no longer employed by the facility.

Preventative Actions

The facility implemented a standardized reporting communication process on 05/14/2026 requiring immediate notification to the Administrator, Administrator designee, or on-call manager upon any allegation or suspicion of abuse.

All staff will complete education regarding:

- Abuse reporting requirements
- Mandatory reporting timelines
- Protection of residents from abuse, neglect, and intimidation

by 05/31/2026, conducted by the Administrator or designee.

Education will include expectations for immediate escalation of concerns regardless of shift or time of occurrence.

Compliance Monitoring

The Administrator or designee will audit all incident reports and allegations of abuse weekly for 4 weeks beginning 05/14/2026, then monthly for 3 months thereafter.

Audits will verify timely reporting, documentation, and appropriate escalation procedures.

Results will be reviewed during monthly QA meetings, with additional education or corrective action provided as indicated.

Scope of Correction

This corrective action applies to all residents and all staff responsible for recognizing, responding to, documenting, and reporting allegations or suspicions of abuse within the facility.

15a Resident abuse report (continued)

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented () - 09/16/2026

42b Abuse/Neglect

2. Requirements

2800.

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

Resident [REDACTED] is diagnosed with Chronic Obstructive Pulmonary Disease (COPD), hypertension, history of pulmonary embolism, depression, required daily oxygen via nasal canula as well as needed medications for COPD, wheezing, and hypertension, among many other medications and diagnoses. The resident was not receiving hospice services. Per the resident's 6/16/25 medical evaluation, [REDACTED] had short- and long-term memory deficits, needed two-person staff assistance, a mechanical lift, staff locomotion via wheelchair, and assistance with repositioning, turning, and transfers. The resident was completely reliant on the residence staff to manage and provide health care services to and for the resident; however the following describes the home's failures to maintain the resident's health and safety.

From October 2025 to November 2025, Resident [REDACTED] had an increase in medication refusals that included refusal of medications to assist with [REDACTED] wheezing and COPD. Resident [REDACTED]'s prescriber was not notified of the resident's refusal of a minimum of 66 medications throughout the month of October and a minimum of 50 medications in November. Per staff interviews, during this time frame the resident had signs of confusion and memory loss, even noting, "I don't think [REDACTED] knew they were refusing medications, what [REDACTED] medications were for. I don't think [REDACTED] understood any of that."

Since [REDACTED] Resident [REDACTED] was prescribed [REDACTED] [REDACTED] vial orally three times a day for wheezing via nebulizer every 6 hours at 8am, 2pm, and 8pm. However, Resident [REDACTED] was not administered [REDACTED] via nebulizer after [REDACTED].

Since [REDACTED], Resident [REDACTED] was ordered [REDACTED] per minute flow rate via nasal canula and may titrate to maintain pulse oximeter greater than or equal to 90% oxygen saturation. In the evening on [REDACTED], and in the morning on [REDACTED] Resident [REDACTED]'s oxygen was titrated to 3 liters per minute, but the residence was unable to obtain the resident's oxygen saturation via a pulse oximeter. The residence did not increase the resident's oxygen flow to the prescribed dose when unable to obtain oxygen saturation levels. In the evening and at bedtime on [REDACTED], Resident [REDACTED] refused to have their oxygen administered and their oxygen saturation measured with a pulse oximeter. The resident's prescriber was not notified of the refusals.

On [REDACTED], Resident [REDACTED] was evaluated for a newly discovered wound on [REDACTED] right posterior calf measuring 4cmX1.5cmX.2cm. The resident's wound specialist ordered [REDACTED] twice daily and [REDACTED] daily for 14 days with food. Resident [REDACTED] was never administered these medications and treatments.

From [REDACTED] until [REDACTED] 5, wound care specialists recorded wound improvement evidenced by decreased surface area. However, Resident [REDACTED] report of pain worsened overtime, indicating a change in health status and cause for concern. On [REDACTED] and [REDACTED], the resident's pain assessment was moderate. On [REDACTED], debridement was attempted but aborted due to pain. On [REDACTED], debridement was attempted but aborted due to pain and "agitation

42b Abuse/Neglect (continued)

and restless" was noted. On [REDACTED] debridement was attempted but aborted due to pain and "agitation and grimacing" was noted.

Per staff interviews, Resident [REDACTED] may be able to ask for help but unable to consistently report [REDACTED] exact pain issue or if [REDACTED] is having trouble breathing. Reported indicators that the resident would be in pain or having trouble breathing would be nonverbal cues like agitation, grimacing, being combative, and breathing hard. Staff noted that in the last week of [REDACTED] life, Resident [REDACTED] was agitated, refusing care, medications and meals, was non-compliant, and was pulling their oxygen nasal canula off multiple times a day.

In October and November 2025, Resident [REDACTED] had a decrease in appetite and ability to eat and drink. Staff recall approximately every couple days, Resident [REDACTED] would not eat breakfast, lunch, and dinner in the same day, "go all day without eating," and often not consume at least two meals per day.

Staff member E did not notify Resident [REDACTED]'s physician of the continual eating and drinking refusals until [REDACTED] reporting, "{the resident} has lost about 16 pounds in 2 months. Appetite over last couple weeks is diminished. Increase difficulty with eating/drinking. Staff have offered to help, but [REDACTED] refuses help." On [REDACTED], Staff member E recorded on Resident [REDACTED]'s progress notes, a document that was not provided to the resident's physician, "PCP faxed regarding weight loss of about 16 pounds in 2 months. Resident with decreased appetite and inability to eat and drink. Staff attempted to help but resident refuses assistance."

The residence did not notify Resident [REDACTED]'s designee until [REDACTED] of the resident's inability and refusals to eat and drink. On [REDACTED], Staff member E informed the designee of the following: "let {the designee} know of refusals of medications and meals/fluids today. It appears [REDACTED] has been refusing meals the past week. [REDACTED] is very tired today, incoherent and feet are pale and cold to the touch. O2 remains in the 90s on 4 LPM." The residence did not notify Resident [REDACTED]'s physician of their refusals to eat and drink from [REDACTED]

Resident [REDACTED] was unable to ambulate and spent a considerable amount of their days in bed in November, but still lost 14.2 pounds from [REDACTED].

Resident [REDACTED]'s [REDACTED] assessment and support plan did not include the resident's diagnosis of depression, [REDACTED] need for wound care specialist services, and still indicated the resident was independent with eating and drinking.

At bedtime on [REDACTED], oxygen was not administered to Resident [REDACTED] and [REDACTED] oxygen saturation level was not measured.

Per staff interviews, the day Resident [REDACTED] ceased to breathe, the resident was in a lot of discomfort, "it was not pleasant" when referencing watching the resident transition to death, [REDACTED] was saying "help me help me," [REDACTED] skin was pale, just the paleness that comes when someone is passing away," "a few hours before passing away [REDACTED] was turning [REDACTED] head from one side to the other, breathing hard," and the resident "couldn't speak."

Resident [REDACTED] ceased to breathe in the residence and the immediate cause of death was hypertensive cardiovascular disease. 911 and other emergency medical services were not contacted until after the resident ceased to breathe.

Plan of Correction

Accepted [REDACTED] 06/03/2026)

Immediate Corrective Action

42b Abuse/Neglect (continued)

Current residents receiving oxygen services, wound care, nebulizer treatments, or who demonstrate refusal patterns related to medications, meals, fluids, or treatments were reviewed by the administrator to ensure physician notification, documentation, and interventions are being completed appropriately. Any identified concerns were addressed at the time of review.

Preventative Actions

The facility initiated a clinical communication and documentation review process on 05/14/2026 for:

- Physician notification of refusals and condition changes
- Documentation of treatments and interventions
- Monitoring of residents with respiratory concerns, wounds, significant weight loss, or refusal patterns
- Timely escalation of resident condition changes to supervisory staff and providers

Licensed nurses, med techs, and supervisory staff will complete education by 05/31/2026 regarding:

- Resident neglect and abuse prevention
- Timely physician and designee notification
- Following prescriber orders
- Documentation expectations for refusals, treatments, and condition changes
- Escalation of significant changes in resident condition

Education will be conducted by the Administrator or designee.

Compliance Monitoring

The Administrator, Resident Services Director, or designee will audit:

- Physician notifications
- Medication and treatment documentation
- Refusal documentation
- Residents receiving oxygen, wound care, or respiratory treatments

weekly for 4 weeks beginning 05/14/2026, then monthly for 3 months thereafter.

Audit findings will be reviewed during monthly QA meetings, with additional education or corrective action provided as indicated.

Scope of Correction

This corrective action applies to all residents receiving medications, treatments, oxygen services, wound care, or monitoring for condition changes, and to all staff responsible for resident care, documentation, physician notification, and implementation of prescriber orders.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented [REDACTED] - 09/16/2026)

42c Dignity/Respect**3. Requirements**

2800.

42c Dignity/Respect (continued)

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [REDACTED], between 5:30pm 8:30pm, Staff member A was on the other side of the building (approximately more than 50 feet away) and heard yelling. Staff member A immediately responded to the yelling, assuming someone had fallen. Upon arrival to Resident [REDACTED]'s bedroom, Staff member A saw Staff member B yelling at Resident [REDACTED] saying, "[REDACTED] she's not here to be a slave to {Resident [REDACTED] [REDACTED] has put {Resident [REDACTED] in bed and that is where you are expected to stay, I am not getting you up and down all night, that is not my job, I am done caring for you, that is not my problem," mixed with vulgar language and using profanities. Staff member A reports the yelling was "unprofessional and not acceptable by any means." Staff member A observed Staff member B continue to yell at the resident for 3 5 minutes instead of assisting the resident, when the resident, who required 2 person assist, was partially hanging off their bed. Staff member A reports Resident [REDACTED] was visibly upset, shaking, and expressing concerns about the treatment [REDACTED] had received in the facility. This incident was also observed by Staff members C and D who responded to Staff member A's call for assistance during the altercation.

Staff member F worked the morning after this incident and recalled Resident [REDACTED] being very upset, and being informed by other staff that Staff member B was "very disrespectful and ignorant to {the resident}."

On [REDACTED], Resident [REDACTED] recalled the altercation with a staff member and reports getting the impression the staff did not like [REDACTED] acting like they didn't want bothered by Resident [REDACTED] the staff was "hostile" towards [REDACTED] and the resident "never did anything for [REDACTED] to be mean to me." During the altercation, Resident [REDACTED] called [REDACTED] daughter and asked [REDACTED] to "get me out of here." Staff member A remembers Resident [REDACTED] appearing very uncomfortable when Staff member B was yelling at [REDACTED] along with looking scared, appearing to flinch when assistance was offered, shaking, and ready to cry. Staff member B was assigned to assist the resident with care on [REDACTED], and when Staff member A assisted Resident [REDACTED] after the altercation, remembers Resident [REDACTED]'s adult brief being "so soiled with sweat and fluid that the brief was falling apart with squishy stuff inside."

Plan of Correction

Accepted [REDACTED] - 06/03/2026)

Immediate Corrective Action

The staff member involved in the incident was immediately removed from resident care responsibilities and is no longer employed by the facility.

Preventative Actions

The facility initiated a resident dignity and respectful communication review process on 05/14/2026.

All direct care staff, med techs, and supervisory staff will complete education by 05/31/2026 regarding:

- Resident rights
- Maintaining resident dignity and respect
- Appropriate staff communication and conduct
- Expectations related to responding to resident care needs
- Reporting concerns related to staff interactions with residents

42c Dignity/Respect (continued)

Education will be conducted by the Administrator or designee.

Compliance Monitoring

The Administrator, Resident Services Director, or designee will conduct observational audits of staff and resident interactions weekly for 4 weeks beginning 05/14/2026, then monthly for 3 months thereafter.

Audits will monitor staff communication, response to resident requests, and maintenance of resident dignity and respect during care interactions.

Audit findings will be reviewed during monthly QA meetings, with additional education or corrective action provided as indicated.

Scope of Correction

This corrective action applies to all residents and all staff responsible for providing resident care and maintaining resident dignity, respect, and appropriate communication within the facility.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented [REDACTED] - 09/16/2026)

65a Fire Safety-1st day**4. Requirements**

2800.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the residence's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff member B, whose first day of work was [REDACTED] did not receive orientation on the following topics: Evacuation procedures, Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, The designated meeting place outside the building or within the fire safe area in the event of an actual fire, Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, The location and use of fire extinguishers, Smoke detectors and fire alarms, and Telephone use and notification of emergency services until [REDACTED].

Repeated Violation [REDACTED]

Plan of Correction

Accept [REDACTED] - 06/03/2026)

Immediate Corrective Action

65a Fire Safety 1st day (continued)

The employee identified in the citation completed orientation related to fire safety and emergency preparedness on 11/05/2025.

Upon receipt of the LIS on 05/06/2026, employee orientation records were reviewed by the Administrator to ensure fire safety and emergency preparedness orientation documentation was present for current staff. Any identified concerns were addressed at the time of review.

Preventative Actions

The facility initiated a review process for new hire orientation documentation on 05/14/2026 to ensure all required fire safety and emergency preparedness education is completed prior to or during the first day of work.

All direct care staff, ancillary staff, and supervisory staff responsible for orientation processes will complete education by 05/31/2026 regarding:

- First day fire safety orientation requirements
- Required emergency preparedness topics
- Documentation requirements for employee orientation

Education will be conducted by the Administrator or designee.

Compliance Monitoring

The Administrator or designee will audit all newly hired employee orientation records weekly for 4 weeks beginning 05/14/2026, then monthly for 3 months thereafter.

Audits will verify completion and documentation of required fire safety and emergency preparedness orientation topics within required timeframes.

Audit findings will be reviewed during monthly QA meetings, with additional education or corrective action provided as indicated.

Scope of Correction

This corrective action applies to all newly hired direct care staff, ancillary staff, substitute personnel, volunteers, and supervisory staff responsible for employee orientation and training within the facility.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented [REDACTED] - 09/16/2026)

142e Secure preventive care**5. Requirements**

2800.

142.e. The residence shall assist the resident to secure preventative medical, dental, vision and behavioral health care as requested by a physician, physician's assistant or certified registered nurse practitioner.

Description of Violation

Since [REDACTED], Resident [REDACTED] was ordered oxygen at 4 liters per minute flow rate via nasal canula and may titrate to maintain pulse oximeter greater than or equal to 90% oxygen saturation. In the evening and at bedtime on [REDACTED] the resident's oxygen was at 4 liters per minute flow rate via nasal canula but the resident's oxygen saturation only measured 85. The resident's physician was not notified of the supplemental oxygen failing to maintain the resident's minimal oxygen saturation level. Additional supports and interventions were never implemented or

142e Secure preventive care (continued)

sought by the residence to bring the resident's oxygen saturation level to the minimal prescribed level.

Plan of Correction**Accepted** [REDACTED] - 06/03/2026)**Immediate Corrective Action**

Resident records, physician communication documentation, oxygen monitoring documentation, and resident intervention documentation related to Resident [REDACTED] were reviewed by the Administrator and Resident Services Director upon receipt of the LIS on 05/06/2026.

Preventative Actions

The facility initiated a respiratory monitoring and physician communication review process on 05/14/2026 for:

- Monitoring and documentation of oxygen saturation levels
- Physician notification related to abnormal oxygen saturation readings
- Documentation of interventions implemented for respiratory concerns
- Escalation of respiratory status changes to supervisory staff and providers

Licensed nurses, med techs, and supervisory staff will complete education by 05/31/2026 regarding:

- Monitoring residents receiving oxygen services
- Physician notification requirements
- Documentation expectations related to oxygen services and respiratory concerns
- Escalation of significant changes in resident condition

Education will be conducted by the Administrator or designee.

Compliance Monitoring

The Administrator, Resident Services Director, or designee will audit:

- Oxygen monitoring documentation
- Physician notifications related to respiratory concerns
- Documentation of interventions for residents receiving oxygen services

weekly for 4 weeks beginning 05/14/2026, then monthly for 3 months thereafter.

Audit findings will be reviewed during monthly QA meetings, with additional education or corrective action provided as indicated.

Scope of Correction

This corrective action applies to all residents receiving oxygen services or respiratory monitoring, and to all staff responsible for resident monitoring, physician notification, documentation, and implementation of resident interventions related to respiratory care.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented [REDACTED] 09/16/2026)**164c Resident refusal-eat/drink****6. Requirements**

2800.

164c Resident refusal-eat/drink (continued)

164.c. If a resident refuses to eat or drink continuously during a 24-hour period, the resident's primary care physician and the resident's designated person shall be immediately notified.

Description of Violation

Per staff interviews, in October and November 2025, Resident [REDACTED] had a decrease in appetite and ability to eat and drink. Staff recall approximately every couple days, Resident [REDACTED] would not eat breakfast, lunch, and dinner in the same day, "go all day without eating," and often not consume at least two meals per day.

Staff member E did not notify Resident [REDACTED]'s physician of the continual eating and drinking refusals until [REDACTED] reporting, "{the resident} has lost about 16 pounds in 2 months. Appetite over last couple weeks is diminished. Increase difficulty with eating/drinking. Staff have offered to help, but [REDACTED] refuses help." On [REDACTED], Staff member E recorded on Resident [REDACTED]'s progress notes, a document that was not provided to the resident's physician, "PCP faxed regarding weight loss of about 16 pounds in 2 months. Resident with decreased appetite and inability to eat and drink. Staff attempted to help but resident refuses assistance."

The residence did not notify Resident [REDACTED]'s designee until 11/29/25 of the resident's inability and refusals to eat and drink. On [REDACTED] Staff member E informed the designee of the following: "let {the designee} know of refusals of medications and meals/fluids today. It appears [REDACTED] has been refusing meals the past week. [REDACTED] is very tired today, incoherent and feet are pale and cold to the touch. O2 remains in the 90s on 4 LPM." The residence did not notify Resident [REDACTED]'s physician of their refusals to eat and drink from [REDACTED].

Plan of Correction**Accept [REDACTED] - 06/03/2026)****Immediate Corrective Action**

Upon receipt of the LIS on 05/06/2026, current residents demonstrating meal, fluid, or nutritional refusal patterns were reviewed to ensure physician and designee notification, documentation, and interventions are being completed appropriately. Any identified concerns were addressed at the time of review.

Preventative Actions

The facility initiated a nutrition and refusal monitoring review process on 05/14/2026 for:

- Documentation of meal and fluid refusals
- Physician and designee notification related to prolonged refusals
- Monitoring of weight loss, appetite changes, and nutritional concerns
- Escalation of concerns related to changes in eating or drinking patterns

Licensed nurses, med techs, direct care staff, and supervisory staff will complete education by 05/31/2026 regarding:

- Requirements related to resident meal and fluid refusals
- Physician and designee notification expectations
- Documentation requirements for refusals and nutritional concerns
- Escalation of significant changes in resident condition

Education will be conducted by the Administrator or designee.

Compliance Monitoring

The Administrator, Resident Services Director, or designee will audit:

- Documentation of meal and fluid refusals
- Physician and designee notifications
- Residents with significant weight loss or nutritional concerns

164c Resident refusal eat/drink (continued)

weekly for 4 weeks beginning 05/14/2026, then monthly for 3 months thereafter.

Audit findings will be reviewed during monthly QA meetings, with additional education or corrective action provided as indicated.

Scope of Correction

This corrective action applies to all residents demonstrating meal or fluid refusal patterns or nutritional concerns, and to all staff responsible for resident monitoring, documentation, physician/designee notification, and implementation of resident interventions related to nutrition and hydration.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented [REDACTED] 09/16/2026)

187a Medication record**7. Requirements**

2800.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

8. Frequency of administration.

Description of Violation

On [REDACTED] Resident [REDACTED] was prescribed leptospermum honey, alginate calcium, gauze island q/ bordered dressing, and peri wound treatment skin prep to be applied to their right posterior calf wound once daily and as needed for 30 days. However, resident's October and November 2025 medication administration record does not include the orders to apply the treatments as needed.

Plan of Correction

Accept [REDACTED] - 06/03/2026)

Immediate Corrective Action

Upon receipt of the LIS on 05/06/2026, current residents receiving wound care treatments, treatment orders, or medications with as needed treatment instructions were reviewed to ensure medication administration records accurately reflect physician orders, including frequency and administration instructions. Any identified concerns were addressed at the time of review.

Preventative Actions

The facility initiated a medication and treatment documentation review process on 05/14/2026 for:

- Accuracy of medication and treatment transcription
- Documentation of administration frequencies
- Documentation of as needed treatment orders
- Verification of medication administration record accuracy against physician orders

Licensed nurses, med techs, and supervisory staff will complete education by 05/31/2026 regarding:

- Medication administration record documentation requirements
- Accurate transcription of physician orders

187a Medication record (continued)

- Documentation of treatment frequencies and as needed orders
- Verification of medication and treatment documentation accuracy

Education will be conducted by the Administrator or designee.

Compliance Monitoring

The Administrator, Resident Services Director, or designee will audit:

- Medication administration records
- Treatment administration records
- Physician orders related to medications and treatments

weekly for 4 weeks beginning 05/14/2026, then monthly for 3 months thereafter.

Audits will verify accuracy and completeness of medication and treatment documentation.

Audit findings will be reviewed during monthly QA meetings, with additional education or corrective action provided as indicated.

Scope of Correction

This corrective action applies to all residents receiving medications or treatments, and to all staff responsible for transcription, documentation, and administration of medications and treatments within the facility.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented [REDACTED] - 09/16/2026)

187c Refusal to take medication**8. Requirements**

2800.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident [REDACTED] refused medications on the following occasions and the residence did not report the refusals to the prescriber:

November 2025

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

187c Refusal to take medication (continued)

October 2025-

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED] bedtime on 5th, 9th, 10th,
- [REDACTED]

Since [REDACTED], Resident [REDACTED] was ordered oxygen at 4 liters per minute flow rate via nasal canula and may titrate to maintain pulse oximeter greater than or equal to 90% oxygen saturation. In the morning and in the evening on [REDACTED] the resident would not allow staff to measure their oxygen saturation with the pulse oximeter. In the evening and at bedtime on [REDACTED] Resident [REDACTED] refused to have their oxygen administered and their oxygen saturation measured with a pulse oximeter. The resident's prescriber was not notified of the refusals.

Plan of Correction**Accept [REDACTED] - 06/03/2026)****Immediate Corrective Action**

Upon receipt of the LIS on 05/06/2026, current residents demonstrating medication refusal patterns or refusal of oxygen administration, treatments, or monitoring were reviewed to ensure physician notification, documentation, and interventions are being completed appropriately. Any identified concerns were addressed at the time of review.

Preventative Actions

The facility initiated a medication refusal monitoring and documentation review process on 05/14/2026 for:

- Documentation of medication, treatment, oxygen, and monitoring refusals
- Physician notification related to refusals
- Monitoring of repeated refusal patterns
- Escalation of concerns related to resident refusals and condition changes

Licensed nurses, med techs, and supervisory staff will complete education by 05/31/2026 regarding:

- Medication refusal documentation requirements
- Physician notification expectations related to refusals
- Documentation of oxygen and treatment refusals
- Escalation of significant changes in resident condition

Education will be conducted by the Administrator or designee.

Compliance Monitoring

The Administrator, Resident Services Director, or designee will audit:

187c Refusal to take medication (continued)

- Medication refusal documentation
- Physician notifications related to refusals
- Residents demonstrating repeated refusal patterns

weekly for 4 weeks beginning 05/14/2026, then monthly for 3 months thereafter.

Audit findings will be reviewed during monthly QA meetings, with additional education or corrective action provided as indicated.

Scope of Correction

This corrective action applies to all residents demonstrating medication, treatment, oxygen, or monitoring refusal patterns, and to all staff responsible for resident monitoring, documentation, physician notification, and implementation of resident interventions related to refusals.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented [REDACTED] 09/16/2026)

187d Follow prescriber's orders**9. Requirements**

2800.

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

Description of Violation

Since [REDACTED], Resident [REDACTED] was prescribed [REDACTED], inhale 1 vial orally three times a day for wheezing via nebulizer every 6 hours at 8am, 2pm, and 8pm. However, Resident [REDACTED] was not administered [REDACTED] after [REDACTED]

Since [REDACTED] Resident [REDACTED] was ordered oxygen at 4 liters per minute flow rate via nasal canula and may titrate to maintain pulse oximeter greater than or equal to 90% oxygen saturation. In the evening on [REDACTED] and in the morning on [REDACTED] Resident [REDACTED]'s oxygen was titrated to 3 liters per minute, but the residence was unable to obtain the resident's oxygen saturation via a pulse oximeter. The residence did not increase the resident's oxygen flow to the prescribe dose when unable to obtain oxygen saturation levels.

At bedtime on [REDACTED], oxygen was not administered to Resident [REDACTED] and their oxygen saturation was not measured.

On [REDACTED] Resident [REDACTED]'s wound specialists ordered [REDACTED] daily for 14 days with food. Resident [REDACTED] was never administered these medications and treatments.

Repeated Violation - [REDACTED]

Plan of Correction

Accept [REDACTED] - 06/03/2026)

Immediate Corrective Action

187d Follow prescriber's orders (continued)

Upon receipt of the LIS on 05/06/2026, current residents receiving medications, oxygen services, respiratory treatments, wound care treatments, or other ongoing physician ordered services were reviewed to ensure physician orders are being followed and documented appropriately. Any identified concerns were addressed at the time of review.

Preventative Actions

The facility initiated a physician order and treatment documentation review process on 05/14/2026 for:

- Implementation of physician ordered medications and treatments
- Oxygen administration and monitoring documentation
- Documentation of respiratory and wound care treatments
- Verification that physician orders are accurately transcribed and followed
- Escalation of concerns related to changes in resident condition

Licensed nurses, med techs, and supervisory staff will complete education by 05/31/2026 regarding:

- Requirements related to following prescriber orders
- Documentation expectations for medications, treatments, and oxygen services
- Monitoring of residents receiving respiratory or wound care services
- Escalation of significant changes in resident condition

Education will be conducted by the Administrator or designee.

Compliance Monitoring

The Administrator, Resident Services Director, or designee will audit:

- Medication administration records
- Treatment administration documentation
- Oxygen administration and monitoring documentation
- Physician orders and transcription accuracy

weekly for 4 weeks beginning 05/14/2026, then monthly for 3 months thereafter.

Audit findings will be reviewed during monthly QA meetings, with additional education or corrective action provided as indicated.

Scope of Correction

This corrective action applies to all residents receiving medications, treatments, oxygen services, respiratory services, or wound care services, and to all staff responsible for transcription, documentation, monitoring, and implementation of physician orders within the facility.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented [REDACTED] - 09/16/2026)

225a2 Assessment – significant change**10. Requirements**

2800.

225a2 Assessment – significant change (continued)

225.a.2. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

On [REDACTED], Resident [REDACTED] was evaluated for a new open area to the back of their right calf measuring 1.5cm X 4cm. The resident received new medication and treatment orders for [REDACTED] wound and required wound care services daily by nursing staff and weekly by wound care specialists. Resident [REDACTED]'s assessment, dated [REDACTED], does not include the change in condition or [REDACTED] need for wound care medications, treatments and specialist's evaluations. An additional written assessment was not completed.

From October to November 2025, Resident [REDACTED] who was bed bound and completely reliant on staff for ambulation, frequently refused meals, had a decreased appetite, was unable to eat and drink independently, occasionally refused help from staff with eating, and had a 14.2 pound weight loss from [REDACTED] to [REDACTED]. However, Resident [REDACTED]'s assessment reads, the resident is independent with eating and drinking and also does not include an assessment of [REDACTED] rapid weight loss. An additional written assessment was not completed.

Resident [REDACTED] was prescribed daily medication for depression for years; however, their [REDACTED] assessment does not include their diagnosis of depression. An additional written assessment was not completed.

Repeated Violation - [REDACTED]

Plan of Correction

Accept [REDACTED] - 06/03/2026)

Immediate Corrective Action

Upon receipt of the LIS on 05/06/2026, current residents with significant changes in condition, including changes related to weight loss, wound care needs, behaviors, mobility, eating and drinking status, or increased care needs were reviewed to ensure assessments and support plans accurately reflect current resident status and services being provided. Any identified concerns were addressed at the time of review.

Preventative Actions

The facility initiated an assessment and support plan review process on 05/14/2026 for:

- Significant changes in resident condition
- Changes in weight, eating and drinking status, or mobility
- New wound care needs or treatment services
- Changes in behaviors, cognition, or mental health status
- Accuracy of assessments and support plans related to resident care needs and services

The Resident Services Director responsible for completion or review of resident assessments will complete education by 05/31/2026 regarding:

- Requirements for significant change assessments
- Timely updates to resident assessments and support plans
- Documentation expectations related to resident condition changes
- Accuracy of assessments related to current resident services and needs

Education will be conducted by the Administrator or designee.

225a2 Assessment – significant change (continued)**Compliance Monitoring**

The Administrator, Resident Services Director, or designee will audit:

- Significant change assessments
- Resident support plans
- Documentation related to changes in resident condition

weekly for 4 weeks beginning 05/14/2026, then monthly for 3 months thereafter.

Audit findings will be reviewed during monthly QA meetings, with additional education or corrective action provided as indicated.

Scope of Correction

This corrective action applies to all residents experiencing significant changes in condition, and to all staff responsible for resident assessments, support plans, documentation, and implementation of resident services within the facility.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented [REDACTED] - 09/16/2026)

252 Records – content**11. Requirements**

2800.

252. Content of Resident Records - Each resident's record must include the following information:

12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.

Description of Violation

Resident [REDACTED] was evaluated in the residence by their physician on [REDACTED] and [REDACTED]; however, the physician's records, recommendations, and evaluations on said occasions were not kept by the residence.

Resident [REDACTED] was evaluated and treated in the residence by wound care specialists on [REDACTED], and [REDACTED]; however, the evaluations, recommendations, orders, and treatments prescribed, and communication regarding wound care services was not kept by the residence.

Plan of Correction

Accepted [REDACTED] - 06/03/2026)

Immediate Corrective Action

Upon receipt of the LIS on 05/06/2026, current residents receiving services from outside providers, including physicians, wound care specialists, home health agencies, hospice, or other healthcare providers, were reviewed to ensure documentation, recommendations, orders, and communications are maintained appropriately within the resident record. Any identified concerns were addressed at the time of review.

Preventative Actions

The facility initiated a resident record and healthcare documentation review process on 05/14/2026 for:

- Physician visit documentation
- Outside provider evaluations and recommendations
- Wound care documentation and treatment orders

252 Records – content (continued)

- Retention of healthcare related communications and records
- Verification that resident records contain current healthcare documentation and orders

Licensed nurses, med techs, and supervisory staff will complete education by 05/31/2026 regarding:

- Resident record documentation requirements
- Retention of healthcare provider documentation and orders
- Documentation expectations related to outside provider services
- Verification of completeness of resident healthcare records

Education will be conducted by the Administrator or designee.

Compliance Monitoring

The Administrator, Resident Services Director, or designee will audit:

- Resident records
- Physician and outside provider documentation
- Treatment and wound care documentation
- Retention of healthcare orders and recommendations

weekly for 4 weeks beginning 05/14/2026, then monthly for 3 months thereafter.

Audit findings will be reviewed during monthly QA meetings, with additional education or corrective action provided as indicated.

Scope of Correction

This corrective action applies to all residents receiving healthcare services, treatments, or evaluations from physicians or outside providers, and to all staff responsible for maintenance, review, and documentation of resident healthcare records within the facility.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented  - 09/16/2026)