pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SHL ROSETTE LLC**
LEGAL ENTITY

To operate **ROSETTE VILLANOVA**
NAME OF FACILITY OR AGENCY

Located at **1745 MONTOGMERY AVENUE, VILLANOVA, PA 19085**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **8**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **April 27, 2026** until **April 27, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **153640**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: April 27, 2026

[redacted]
SHL Rosette, LLC
1745 Montgomery Avenue
Villanova, Pennsylvania 19085

RE: Rosette Villanova
1745 Montgomery Avenue
Villanova, Pennsylvania 19085
License #: 153640

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on February 19, 2026, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

April 23, 2026

[redacted]
SHL ROSETTE LLC
1745 MONTGOMERY AVENUE
VILLANOVA, PA, 19085

RE: ROSETTE VILLANOVA
1745 MONTOGMERY AVENUE
VILLANOVA, PA, 19085
LICENSE/COC#: 15364

Dear [redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/19/2026 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: *ROSETTE VILLANOVA* **License #**: *15364* **License Expiration**: *05/17/2026*

Address: *1745 MONTOGMERY AVENUE, VILLANOVA, PA 19085*

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

Administrator

Name: [redacted]

Legal Entity

Name: *SHL ROSETTE LLC*

Address: *1745 MONTGOMERY AVENUE, VILLANOVA, PA, 19085*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *R-4* **Date**: *06/27/2025* **Issued By**: *Lower Merion Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *15* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *02/19/2026*

Inspection Dates and Department Representative

02/19/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served**: *8*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *8*

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

Have Mobility Need: *7* **Have Physical Disability**: *0*

Inspections / Reviews

02/19/2026 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/16/2026*

03/18/2026 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/17/2026*

Inspections / Reviews *(continued)*

04/23/2026 - Document Submission

Submitted By: [redacted]

Date Submitted: *04/17/2026*

Follow-Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 2/19/2026 the home's current license, dated 11/17/2025, was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

the current license was immediately located and replaced in the frame that day. Checking on the date in addition ton to checking the license was on display was added to the monthly audit to be performed monthly by the administrator. An additional monthly audit was performed on Wednesday March 11 . A list of all materials needed to be displayed at the door remains on display

Licensee's Proposed Overall Completion Date: *03/13/2026*

Evidence of Completion ***Implemented ([redacted] 04/23/2026)***

See attached.

44g - Telephone Number

2. Requirements

2600.
44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone number of the local ombudsman is not posted in a conspicuous and public place in the home. On 2/19/2026 the number that was posted was outdated.

Plan of Correction ***Accept ([redacted] 03/18/2026)***

The correct ombudsman contact information was displayed 2/20/26 when the ombudsman arrived to drop off new stickers for us. The actual number to cross check has now been added to the monthly audit to be performed by the administrator monthly. An additional audit was performed by the administrator on March 11, 2026 and to regularly verify and update posted contact information to meet compliance standards. Checking the DHS website for important changes or notices has also been added to the monthly Audit performed by the administrator.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Evidence of Completion ***Implemented [redacted]S - 04/23/2026)***

See attached.

51 - Criminal Background Check

3. 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).

51 - Criminal Background Check *(continued)*

Description of Violation

Staff person A was hired on [redacted]/2025, a background check was not completed until 10/15/2025.

Repeat Violation: 8/7/2025

Plan of Correction ***Accept [redacted] - 03/18/2026)***

A new audit sheet was created by the administrator for the HR manager and performed ensuring all employees have proper background check before entering the floor. An audit using the new sheets was immediately done in full for all employees and completed Mach 12, 2026. The HR manager has been re- trained again on proper qualifications from the department, given a handout on educational requirements, the Older adults protective services act regarding background checks. New audit sheet attached will be used for all new employees . [redacted] is fully aware of what needs to be obtained before every employee is on the floor.
As an added safeguard, All new employee files will be re-audited by Operations manager and submitted to the administrator and approved before any new employee arrives on the floor.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of a completed audit for all employees as well as completed audits for any new hires.

Evidence of Completion ***Implemented [redacted] - 04/23/2026)***

See attached.

54a - Direct Care Staff

4. Requirements

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

Description of Violation

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

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

Repeat Violation: 8/7/2025

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Staff member A and B were immediately removed from the floor while we await the necessary waivers. A new audit sheet was created by the administrator for the HR manager and performed ensuring all employees have proper educational requirements before entering the floor. An audit was immediately done in full for all employees and completed Mach 12, 2026. The HR manager has been re- trained again on proper qualifications from the department, a handout on educational requirements, the Older adult protection services act regarding background

54a - Direct Care Staff (continued)

checks, and a new audit sheet attached . [redacted] is fully aware of what needs to be obtained before every employee is on the floor.
As an added safeguard, All new employee files will be re-audited by Operations manager and submitted to the administrator before any new employee is clear to arrive on the floor

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of a completed audit for all employees as well as completed audits for any new hires.

Evidence of Completion ***Implemented ([redacted] - 04/23/2026)***

See attached.

65a - FS Orientation 1st Day

5. Requirements

2600.
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 home'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 person C, who was hired with the company [redacted] 2023, whose first day of work was at this home is unknown, did not receive orientation on the following topics specific to the home: 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.

Staff person D, who was hired with the company [redacted] /2023, whose first day of work was at this home is unknown, did not receive orientation on the following topics specific to the home: 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.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Staff person C, and D were immediately given orientation on the following topics specific to the home: evacuation

65a - FS Orientation 1st Day (continued)

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, , the location and use of fire extinguishers, smoke detectors and fire alarms, and telephone use and notification of emergency services.

A new audit sheet was created by the administrator for the HR manager and performed ensuring all employees have the proper orientation before setting foot on the floor. An audit was immediately done in full for all employees and completed Mach 12, 2026. The HR manager has been re- trained again on proper qualifications from the department, a handout on educational requirements, the Older protection services act regarding background checks, and a new audit sheet attached . [redacted] is fully aware of what needs to be obtained before every employee is on the floor. Audits will be done every month on the 15th or next business day.

As an added safeguard, All new employee files will be re-audited by Operations manager and submitted to the administrator before any new employee arrives on the floor.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of a completed audit for all employees as well as completed audits for any new hires.

Evidence of Completion ***Implemented [redacted] - 04/23/2026)***

See attached.

65b - Rights/Abuse 40 Hours

6. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person E completed [redacted] 40th scheduled work hour on or about 10/16/2025. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), and reporting of reportable incidents and conditions.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Staff person E immediately completed her training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), and reporting of reportable incidents and conditions.

A new audit sheet was created by the administrator for the HR manager and performed ensuring all employees have the proper orientation before setting foot on the floor. An audit was immediately done in full for all employees and completed Mach 12, 2026. The HR manager has been re- trained again on proper qualifications from the department, a handout on educational requirements, the Older protection services act regarding background

65b - Rights/Abuse 40 Hours (continued)

checks, and a new audit sheet attached . [redacted] is fully aware of what needs to be obtained before every employee is on the floor. Audits will be done every month on the 15th or next business day. As an added safeguard, All new employee files will be re-audited by Operations manager and submitted to the administrator before any new employee arrives on the floor.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of a completed audit for all employees as well as completed audits for any new hires.

Evidence of Completion ***Implemented [redacted] - 04/23/2026)***

See attached.

65c - Ancillary Staff Orientation

7. Requirements

2600.
65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person E, whose first day of work was [redacted]/2025, did not have a general orientation to [redacted] specific job functions.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Ancillary staff person E, immediately had an orientation of her specific job duties in writing. A new audit sheet was created by the administrator for the HR manager and performed ensuring all employees have the proper orientation before setting foot on the floor. An audit was immediately done in full for all employees and completed Mach 12, 2026. The HR manager has been re- trained again on proper qualifications from the department, a handout on educational requirements, the Older adult protective services act regarding background checks, and a new audit sheet for axillary employees attached . [redacted] is fully aware of what needs to be obtained before every employee is on the floor. Audits will be done every month on the 15th or next business day. As an added safeguard, All new employee files will be re-audited by Operations manager and submitted to the administrator before any new employee arrives on the floor.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of a completed audit for all employees as well as completed audits for any new hires.

Evidence of Completion ***Implemented [redacted] - 04/23/2026)***

See attached.

65d - Initial Direct Care Training

8. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

65d - Initial Direct Care Training *(continued)*

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [redacted]/2025, began providing unsupervised ADL services on 9/1/2025. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test until 11/14/2025.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

A new audit sheet was created by the administrator for the HR manager and performed ensuring all employees have the proper orientation before setting foot on the floor. An audit was immediately done in full for all employees and completed Mach 12, 2026. The HR manager has been re- trained again on proper qualifications from the department, a handout on educational requirements, the Older protection services act regarding background checks, and a new audit sheet attached . [redacted] is fully aware of what needs to be obtained before every employee is on the floor. Audits will be done every month on the 15th or next business day. As an added safeguard, All new employee files will be re-audited by Operations manager and submitted to the administrator before any new employee arrives on the floor.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of a completed audit for all employees as well as completed audits for any new hires.

Evidence of Completion ***Implemented [redacted] - 04/23/2026)***

See attached.

82c - Locking Poisonous Materials

9. 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 2/19/2026 at 9:52 AM Kirkland Dishwasher Pac and a bottle of Jet Dry, both with a manufacture's label indicating "If swallowed call poison control immediately", was unlocked, unattended, and accessible to residents under the sink in the kitchen. Not all the residents of the home, including resident 1, have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 10/15/2025, 9/18/2025, and 8/7/2025

Plan of Correction ***Accept [redacted] - 03/18/2026)***

administrator immediately ensured all poisonous materials were locked and inaccessible to residents. A sweep of the premises was performed to identify all areas where poisonous materials are stored. Chefs were educated on importance of securing the cleaning supply under the sink and locking after use and signed off on the training. Supervisor daily rounds have been updated to specifically call out under the sink storage. Management will continue to audit daily the correct locking of the kitchen products. Last audit performed 3/12

Licensee's Proposed Overall Completion Date: *03/12/2026*

82c - Locking Poisonous Materials *(continued)*

Update: *03/18/2026*

Please provide documentation of completed audit.

Evidence of Completion ***Implemented [redacted] 04/23/2026)***

See attached.

100b - Removal Snow/Obstructions

10. 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 2/19/2026 at 9:00 AM, there was an approximately 2 inches of accumulation of icy snow on the ramp outside the back patio exit, and covering the entire enclosed courtyard. There was no cleared pathways leading to the gate. It last snowed approximately 2 inches on 1/26/2026.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

snow and ice were immediately removed from the back walkways and ramps. The contracted snow removal company was called and service added to include salting and shoveling the back premesis. A shovel was also purchased for employees to use should the company be unable to get here. Ice and snow removal monitoring has also been added to the daily checklist rounds for supervisors to include under hazards and a number of the company to call should they find it inadequete.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Evidence of Completion ***Implemented [redacted] - 04/23/2026)***

See attached.

101j5 - Bedside Table/Shelf

11. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident 2's bed in bedroom.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Resident 2 is immobile and is unable to use a shelf. However A very small shelf was bought and installed for resident 2 to remain compliant. An audit was done of the remaining residents rooms to ensure compliance. The supervisor rounds will remain daily for the rooms by the supervisors and the monthly med/room audit by the administrator will continue to be done every month by the 15th.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of additional completed audits.

Evidence of Completion ***Implemented [redacted] - 04/23/2026)***

See attached.

101j7 - Lighting/Operable Lamp

12. Requirements

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

Description of Violation

Resident 2 does not have access to a source of light that can be turned on/off at bedside.
Resident 3 does not have access to a source of light that can be turned on/off at bedside.

Repeat Violation Date: 9/18/25

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Resident 2 and 3 are unable to use a lamp and are immobile. However a very small stick light was bought and installed for resident 2 and 3 just to remain compliant. An audit was done of the remaining residents rooms to ensure compliance. The supervisor rounds will remain daily for the rooms by the supervisors and the monthly med/room audit by the administrator will continue to be done every month by the 15th.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of additional completed audits.

Evidence of Completion ***Implemented ([redacted] - 04/23/2026)***

See attached.

121a - Unobstructed Egress

13. 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 2/19/2026 at approximately10:00 AM, the exit door behind the kitchen was unable to be opened without exerting extreme force.

Repeat Violation Date: 9/18/25

Plan of Correction ***Accept ([redacted] - 03/18/2026)***

Due to the extremely icy conditions the additional back door which is very rarely used was unable to open easily. The contractor was immediately called and though he oiled the door , he also pointed to ice being the culprit. And audit was done for the rest of the doors and no issues found. Auditing that the doors work properly in all weather conditions has been added to the daily supervisor rounds. They will also be tested in the monthly audits by the administrator

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of additional completed audits.

Evidence of Completion ***Implemented ([redacted] - 04/23/2026)***

See attached.

132d - Evacuation

14. 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.

Description of Violation

During the fire drill on 12/5/2025 at 5:45 AM, residents evacuated to a public thoroughfare or public area in 11 minutes and 45 seconds. The home has a safe evacuation time of 10 minutes specified in writing within the past year by a fire safety expert. The home exceeded the safe evacuation time of 10 minutes seconds during this drill.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Upon review the drill was only about a minute and 1/2 over. The drill was done a few days after new beds were delivered. The staff spent a lot of time dealing with the slow lowering beds and the time it took to lower to the ground. The nighttime bed procedure was updated and changed to have resident beds be on a lower setting and not at the highest setting to save time in evacuation. Memo was posted and emailed including the need for follow up loops to express any ideas or issues with evacuations and suggestions to make faster. Two follow up fire drills were done March 12 and 13 to ensure success. Both fire drills were successful. Keeping the beds on a lower setting for bedtime was added to the daily night time supervisor rounds as a permanent fixture.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Evidence of Completion ***Implemented ([redacted] - 04/23/2026)***

See attached.

183b - Meds and Syringes Locked

15. 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 2/19/2026 at 9:52 AM, lidocaine 4% patches and diclofenac sodium topical gel, was unlocked, unattended, and accessible in resident 4's bedroom.

Mederma PM was unlocked in resident 2's bathroom.

Repeat Violation: 10/15/2025 and 9/18/2025.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Resident 2's medications were immediately secured in a lock box like the other residents. Administrator conducted an immediate sweep of all resident rooms to identify and secure any unsecured medications. A memo was sent out to staff to remind them of the need to keep all resident medications, creams etc in the lock box. Supervisor was again briefed and trained on 2600.183.b. and reminded to do the rounds each day to ensure staff is securing the medications properly. Monthly audits of med/room continued to be done monthly on the 15th

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of additional completed audits.

183b - Meds and Syringes Locked *(continued)*

Evidence of Completion ***Implemented (- 04/23/2026)***

See attached.

225a - Assessment 15 Days

16. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 5's assessment, dated /2026, does not include the signature of the assessor.

Repeat Violation Date: 9/18/25

Plan of Correction ***Accept - 03/18/2026)***

Resident 5's assessment was immediately completed with the assessor's signature. Care coordinator was informed and trained that signature is needed even for a 15 day initial assessment and signed off on the memo. An immediate sweep was performed of all resident raspss and they were found to be complaint. Signature for initial assessment was added to the monthly document Audit to be performed monthly on the 15th .

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of additional completed audits.

Evidence of Completion ***Implemented - 04/23/2026)***

See attached.

225c - Additional Assessment

17. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 1's assessment, dated /2025, does not include the need for a bedside mobility device.

Plan of Correction ***Accept (- 03/18/2026)***

Resident was confirmed to not need bedside mobility device and these were installed by a company in error when delivering new bed. A sweep of the remaining residents showed no other bedrails. The rails were removed and stored in the basement. Checking on the residents beds to inspect for rails, and either ensure a rail did not get installed in error or that it is compliant has been added to the supervisor rounds and also the monthly audit.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of additional completed audits.

225c - Additional Assessment *(continued)*

Evidence of Completion ***Implemented [redacted] - 04/23/2026)***

See attached.

227g -Support Plan Signatures

18. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 1's family member is listed as participating in the development of [redacted] support plan on 9/26/25. However, the resident's family member did not sign the support plan and there is no mark indicating an inability or refusal to sign.

Plan of Correction ***Accept [redacted] - 03/18/2026)***

Resident 1's assessment was immediately completed with the family member's signature. Care coordinator was informed that signature is needed even for a 15 day initial assessment , by a family member if taking part, and by the resident (or an unable to sign notation) and signed off on the memo. A Sweep was performed of all resident rasps and they were found to be compliant. Signature from family member or an unable to sign notation was added to the monthly document Audit.

Licensee's Proposed Overall Completion Date: *03/12/2026*

Update: *03/18/2026*

Please provide documentation of additional completed audits.

Evidence of Completion ***Implemented ([redacted] - 04/23/2026)***

See attached.