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

May 8, 2026

[redacted]
MERCY LIFE CENTER CORPORATION
[redacted]
ATTN: LICENSING/COMPLIANCE
[redacted]

RE: GARDEN VIEW MANOR
441 SWISSVALE AVENUE
PITTSBURGH, PA, 15221
LICENSE/COC#: 44069

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/25/2026 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: *GARDEN VIEW MANOR* **License #**: *44069* **License Expiration**: *05/27/2026*

Address: *441 SWISSVALE AVENUE, PITTSBURGH, PA 15221*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *MERCY LIFE CENTER CORPORATION*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *04/08/2010* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *53* **Waking Staff**: *40*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *02/25/2026*

Inspection Dates and Department Representative

02/25/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served**: *50*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *50* **Are 60 Years of Age or Older**: *25*

Diagnosed with Mental Illness: *50* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

02/25/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/09/2026*

04/14/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/05/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/20/2026*

Inspections / Reviews *(continued)*

04/21/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/05/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/05/2026*

05/08/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/05/2026*

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 [redacted] at approximately 5:15pm, resident [redacted] reported an allegation of physical abuse against resident [redacted] however, this incident was not reported to the local Area Agency on Aging until [redacted] at approximately 9:45pm.

On [redacted] at approximately 1:30pm, resident [redacted] reported an allegation of physical abuse against resident [redacted] however, this incident was not reported to the local Area Agency on Aging until [redacted] at approximately 10:00pm.

Plan of Correction ***Accept [redacted] - 04/21/2026)***

Plan of Correction:

• On 3/25/26 the home's administrator/Supervisor(s) provided training to the home's staff on the topic of incident reporting which included abuse reporting process in accordance with Regulation 2600.15 and a review of all reportable incidents and how to complete incident reports in accordance with Regulation 2600.16c and 2600.15.

• Documentation of the staff education, including the date, length of training, instructor, and topics covered, shall be kept in accordance with Regulation 2600.65(j) and maintained in the staff training binder in the ground floor supervisor's office.

• On 3/30/26 the home's administrator/designee reviewed the Incident Report Training binders to make sure that all incident reporting requirements and materials for DHS and APS are contained in the binder to ensure the reporting process is adherent to reporting Regulations 2600.16.c. and 2600.15.

• On 4/1/26 the home's administrators ensured copies of the Incident Report Training binders are located in all staff offices.

• By 4/5/26 the home's administrator/Supervisors/designee will compile and review incidents by type to monitor incident report completion within 24 hours for the nineteen reportable events to ensure compliance with Regulations 2600.16.c. and 2600.15. This tracker will also be used to consistently review the incident report process with staff as appropriate during shift change meetings or monthly staff meeting(s). The tracker will be reviewed by the home's administrator weekly and completion will be confirmed with a signature at the end of each month. The reviewed trackers will be maintained in the ground floor supervisor's office.

• Beginning 4/6/26 the home's administrators/Supervisors, Team Leads or designee will monitor and review incidents, reporting, and notifications for reportable incidents and abuse daily during shift change staff meetings to ensure that abuse reporting is immediately verbally reported to APS and incident reports are completed for APS and DHS within 24 hours of discovery to prevent future occurrences and to ensure ongoing compliance with

15a Resident Abuse Report (continued)

Regulations 2600.16.c. and 2600.15.

• Beginning 4/6/26, after staff refresher training has occurred, if the incident reporting process continues to be delayed, the home's administrators/Supervisors will provide feedback to their Senior Manager on the day of, or the next workday. In cases of repeated non compliance, Human Resources will be consulted to determine appropriate corrective action.

• On April 14, 2026, PCHA/Supervisor reviewed compiled incident reports by category to identify the root cause of untimely AAA notifications. The review determined that delays were primarily due to staff misclassifying abuse related incidents and failing to promptly escalate unclear situations to leadership.

• By April 20, 2026, all Direct Care Staff will sign an acknowledgment form stating: "I have been trained on identifying abuse, abuse reporting and procedures, and understand that any aggressive physical contact involving a resident or staff member must be treated as abuse. I am aware that Abuse is a reportable incident and that all staff, including myself, are required to submit all reportable incidents within department timeframes, follow the incident reporting policy, and refer to the incident reporting training binder for guidance. All incidents must be immediately escalated to leadership, including any unclear issues that may be considered abuse."

Licensee's Proposed Overall Completion Date: *04/20/2026*

Implemented [redacted] - 05/08/2026)

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 [redacted] at approximately 5:15pm, resident [redacted] reported an allegation of physical abuse against resident [redacted] however, this incident was not reported to the Department until [redacted] at 7:22pm.

REPEAT VIOLATION: [redacted], et.al., [redacted]

Plan of Correction ***Accept [redacted] - 04/21/2026)***

Plan of Correction:

• On 3/25/26 the home's administrator/Supervisor(s) provided training to the home's staff on the topic of incident reporting which included abuse reporting process in accordance with Regulation 2600.15 and a review of all reportable incidents and how to complete incident reports in accordance with Regulation 2600.16c and 2600.15.

• Documentation of the staff education, including the date, length of training, instructor, and topics covered, shall be kept in accordance with Regulation 2600.65(j) and maintained in the staff training binder in the ground floor supervisor's office.

16c - Written Incident Report (continued)

• On 3/30/26 the home's administrator/designee reviewed the Incident Report Training binders to make sure that all incident reporting requirements and materials for DHS and APS are contained in the binder to ensure the reporting process is adherent to reporting Regulations 2600.16.c.and 2600.15.

• On 4/1/26 the home's administrators ensured copies of the Incident Report Training binders are located in all staff offices.

• By 4/5/26 the home's administrator/Supervisors/designee will compile and review incidents by type to monitor incident report completion within 24 hours for the nineteen reportable events to ensure compliance with Regulations 2600.16.c. and 2600.15. This tracker will also be used to consistently review the incident report process with staff as appropriate during shift change meetings or monthly staff meeting(s). The tracker will be reviewed by the home's administrator weekly and completion will be confirmed with a signature at the end of each month. The reviewed trackers will be maintained in the ground floor supervisor's office.

• Beginning 4/6/26 the home's administrators/Supervisors, Team Leads or designee will monitor and review incidents, reporting, and notifications for reportable incidents and abuse daily during shift change staff meetings to ensure that abuse reporting is immediately verbally reported to APS and incident reports are completed for APS and DHS within 24 hours of discovery to prevent future occurrences and to ensure ongoing compliance with Regulations 2600.16.c. and 2600.15.

• Beginning 4/6/26, after staff refresher training has occurred, if the incident reporting process continues to be delayed, the home's administrators/Supervisors will provide feedback to their Senior Manager on the day of, or the next workday. In cases of repeated non-compliance, Human Resources will be consulted to determine appropriate corrective action.

• On April 14, 2026, PCHA/Supervisor reviewed compiled incident reports by category to identify the root cause of untimely notifications to the Department. The review determined that delays were primarily due to staff misclassifying abuse-related incidents and failing to promptly escalate unclear situations to leadership.

• By April 20, 2026, all Direct Care Staff will sign an acknowledgment form stating: "I have been trained on identifying abuse, abuse reporting and procedures and understand that any aggressive physical contact involving a resident or staff member must be treated as abuse. I am aware that Abuse is a reportable incident and that all staff, including myself, are required to submit all reportable incidents within department timeframes, follow the incident reporting policy, and refer to the incident reporting training binder for guidance. All incidents must be immediately escalated to leadership, including any unclear issues that may be considered abuse."

Licensee's Proposed Overall Completion Date: *04/20/2026*

16c - Written Incident Report *(continued)*

Implemented [redacted] - 05/08/2026)

18 - Compliance With Laws

3. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Adult Protective Services Act 70 of 2010 requires an employee or an administrator who has reasonable cause to suspect that a resident is a victim of abuse or neglect to immediately make an oral report to the local contracted provider of protective services agency. On [redacted] at approximately 5:15pm, resident [redacted] reported an allegation of physical abuse against resident [redacted] however, this incident was not reported to the local contracted provider of protective services agency unti[redacted] at 9:45pm.

Plan of Correction ***Accept[redacted] - 04/21/2026)***

Plan of Correction:

• On 3/25/26 the home's administrator/Supervisor(s) provided training to the home's staff on the topic of incident reporting which included abuse reporting process in accordance with Regulation 2600.15 and a review of all reportable incidents and how to complete incident reports in accordance with Regulation 2600.16c and 2600.15.

• Documentation of the staff education, including the date, length of training, instructor, and topics covered, shall be kept in accordance with Regulation 2600.65(j) and maintained in the staff training binder in the ground floor supervisor's office.

• On 3/30/26 the home's administrator/designee reviewed the Incident Report Training binders to make sure that all incident reporting requirements and materials for DHS and APS are contained in the binder to ensure the reporting process is adherent to reporting Regulations 2600.16.c.and 2600.15.

• On 4/1/26 the home's administrators ensured copies of the Incident Report Training binders are located in all staff offices.

• By 4/5/26 the home's administrator/Supervisors/designee will compile and review incidents by type to monitor incident report completion within 24 hours for the nineteen reportable events to ensure compliance with Regulations 2600.16.c. and 2600.15. This tracker will also be used to consistently review the incident report process with staff as appropriate during shift change meetings or monthly staff meeting(s). The tracker will be reviewed by the home's administrator weekly and completion will be confirmed with a signature at the end of each month. The reviewed trackers will be maintained in the ground floor supervisor's office.

• Beginning 4/6/26 the home's administrators/Supervisors, Team Leads or designee will monitor and review incidents, reporting, and notifications for reportable incidents and abuse daily during shift change staff meetings to ensure that abuse reporting is immediately verbally reported to APS and incident reports are completed for APS and DHS within 24 hours of discovery to prevent future occurrences and to ensure ongoing compliance with

18 - Compliance With Laws (continued)

Regulations 2600.16.c. and 2600.15.

• Beginning 4/6/26, after staff refresher training has occurred, if the incident reporting process continues to be delayed, the home's administrators/Supervisors will provide feedback to their Senior Manager on the day of, or the next workday. In cases of repeated non-compliance, Human Resources will be consulted to determine appropriate corrective action.

• On April 14, 2026, PCHA/Supervisor reviewed compiled incident reports by category to identify the root cause of untimely notifications to APS. The review determined that delays were primarily due to staff misclassifying abuse-related incidents and failing to promptly escalate unclear situations to leadership.

• By April 20, 2026, all Direct Care Staff will sign an acknowledgment form stating: "I have been trained on identifying abuse, abuse reporting and procedures and understand that any aggressive physical contact involving a resident or staff member must be treated as abuse. I am aware that Abuse is a reportable incident and that all staff, including myself, are required to submit all reportable incidents within department timeframes, follow the incident reporting policy, and refer to the incident reporting training binder for guidance. All incidents must be immediately escalated to leadership, including any unclear issues that may be considered abuse."

Proposed Overall Completion Date: 04/20/2026

Licensee's Proposed Overall Completion Date: *04/20/2026*

Implemented ([redacted] - 05/08/2026)

42b - Abuse

4. Requirements

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

Description of Violation

On [redacted] at approximately 5:15pm while resident [redacted] was standing in line for dinner, resident [redacted] punched resident [redacted] in the back of the head near the left shoulder/neck area. Resident [redacted] sustained a throbbing pain in the head, shoulder and neck area.

On [redacted] at approximately 1:30pm, resident [redacted] was sitting in the home's activity/television room when resident [redacted] walked up to resident [redacted] and punched resident [redacted] in the face near the right eye. Resident [redacted] sustained a cut under the right side of the nose, bruising and scratches around the right eye and a black eye.

42b Abuse (continued)

On [redacted] at approximately 1:00pm, resident [redacted] walked up to resident [redacted] in the hallway and said, "I will kill you" then fully swung [redacted] arm and hit resident [redacted] in the face. Resident [redacted] sustained a red mark on the cheek.

REPEAT VIOLATION: [redacted] et. al.

Plan of Correction ***Directed [redacted] - 04/21/2026)***

Plan of Correction:

• Effective immediately, to prevent further occurrences and to support on going compliance with Regulation 2600.42.b Abuse, the home's administrator/Supervisors and Senior Manager will assess all residents' safety, staff safety and the safety of the individual resident who is exhibiting behaviors of abuse. The home will assess each individual resident who is exhibiting behaviors of abuse and discuss with the resident and their treatment team members whether the resident is appropriate to continue to be a resident of the home.

• On 3/25/26 the home's administrator/Supervisors provided a review of Regulation 2600.42b Abuse: A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way to ensure that abuse reporting is verbally reported to APS immediately and incident reports are completed to APS and DHS within 24 hours of discovery to prevent future occurrences and to ensure ongoing compliance with Regulation 2600.42.b. All staff were reminded that failure to assist residents is considered neglect. Garden View affirms that residents will not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment, or disciplined in any way. All staff are required to respond promptly to resident requests for assistance, and failure to do so will result in corrective action.

• Documentation of the staff education, including the date, length of training, instructor, and topics covered, shall be kept in accordance with Regulation 2600.65(j) and maintained in the staff training binder in the ground floor supervisor's office.

• On 3/30/26 the home's administrator/designee reviewed the Incident Report Training binders to make sure that all incident reporting requirements and materials for DHS and APS are contained in the binder to ensure the reporting process was adherent to reporting Regulation 2600.18.

• On 4/1/26 the home's administrator ensured copies of the Incident Report Training binders are located in all staff offices.

• Beginning 4/6/26, after staff refresher training has occurred, if the incident reporting process continues to be delayed, the home's administrators/Supervisors will provide feedback to their Senior Manager on the day of, or the next workday. In cases of repeated non compliance, Human Resources will be consulted to determine appropriate corrective action.

• By 4/9/26, the home's administrator/Supervisors will revise the current resident monitoring and progress tracking process to ensure all staff are documenting in the electronic medical record (Avatar) for on going monitoring of

42b Abuse (continued)

residents' needs, ongoing care provided, attempts to provide care, assistance, interventions and treatment provided, based on their DME and RASP to ensure the best possible care and support is provided to the residents, to prevent future occurrences and to ensure ongoing compliance with Regulation 2600.42.b. (DIRECTED: Beginning on 4/24/26: The administrator/designee shall review the documentation on a daily basis and provide appropriate interventions to ensure residents are free from abuse. LM 4/21/26).

• Beginning 4/9/26 Direct Care Staff will document check ins with residents weekly and any safety concerns, changes, interventions and/or treatment provided on the day of the event. This documentation will be recorded in the electronic medical record (Avatar). The home's administrator/Supervisors or Team Leads will monitor and review Direct Care Staff documentation and enter any missing significant documentation needed and record this review at least twice a month on the Bi Weeklies Tracker form. The Bi Weeklies Tracker forms will be maintained in the "Quality Assurance" binder in the ground floor supervisor's office. (DIRECTED: By 5/5/26: The home shall conduct a quality management review which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. LM 4/21/26).

• By 4/16/26, all Direct Care Staff & Nurses will complete the online trainings on abuse prevention and mandatory reporting, provided by the Department of Human Services for the "Mandatory Reporter Training". This training covers recognizing, preventing, and reporting all forms of abuse, neglect, intimidation, and mistreatment in accordance with Regulation 2600.42(b). This training will be taken by staff in order to prevent future occurrences and to ensure ongoing compliance with Regulation 2600.42b. Documentation of education is kept in accordance with Regulation 2600.65(j) and maintained in the staff files in the supervisor's office.

• On February 10, 2026, Resident [redacted] was hospitalized for behavioral health treatment and remains a resident of the home at this time. The PCHA/Supervisor and On Site Nurse have been actively participating in ongoing treatment progress meetings with Western Psychiatric Hospital treatment team. During this time, medication adjustments have been implemented, resulting in gradual behavioral changes. The team is currently evaluating whether these changes may represent a new baseline for Resident [redacted]

• The PCHA/Supervisor and On Site Nurse will continue to participate in ongoing treatment meetings to monitor progress and assess behavioral changes. If these changes indicate care needs beyond what the home can safely provide, the home will collaborate with the treatment team to identify appropriate alternatives to ensure the health, safety, and well being of Resident [redacted] and all other residents.

• As of 4/20/2026 the treatment team's recommendation is that Resident [redacted] is referred to a higher level of care and this referral is in the process of being submitted.

• If resident [redacted] returns to the home, Staff will provide increased monitoring, intervene promptly at signs of agitation, and separate from other residents as needed to maintain safety. Staff will use de escalation techniques and closely observe for behavioral triggers. Ongoing communication with Resident [redacted]s Psychiatric Practitioner will be maintained regarding the resident's response to medications and observed behaviors to support stability and ensure the safety and well being of all residents. If aggressive behavior reoccurs, the home will reassess the resident's appropriateness for continued placement to protect the safety and well being of all residents.

42b - Abuse (continued)

Proposed Overall Completion Date: 04/20/2026

Directed Completion Date: *05/05/2026*

Implemented [redacted] - 05/08/2026)

88a - Surfaces

5. 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

At 10:06am, the doorknob on the door to the 2nd floor stairwell D was separated from the door and could not be turned and used to open the door.

Plan of Correction ***Accept [redacted] - 04/14/2026)***

Plan of Correction:

• On 2/25/26 at 12:10 PM the emergency doorknob was repaired.

• Effective immediately, any damaged, missing or hazardous conditions will be reported for repair upon discovery.

• Effective immediately, if the landlord is responsible for the repair, the maintenance or housekeeping supervisor will follow up with the landlord to ensure the work is completed within 1 week. If the work is not completed, the maintenance and housekeeping supervisor will consult with the home's administrator, and a plan will be developed to ensure the work is completed by the maintenance or housekeeping team within 2 weeks maximum.

• On 2/25/26 the home's administrator met with the housekeeping and maintenance supervisors and reviewed Regulation 2600.88.a.

• On 2/25/26, the home's administrator revised the home's Risk Management Safety Inspection Checklist to include checks that all floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards, including the emergency doors and doorknobs on emergency doors are in good working condition.

• Beginning 2/25/26 the home's administrator and housekeeping supervisor will review the Risk Management Safety Inspection Checklist for accuracy and compliance monthly.

88a - Surfaces (continued)

• Beginning 2/25/26 the housekeeping supervisor/maintenance supervisor/designee and their Senior Manager will complete a visual inspection of all areas of the home monthly and document findings on the revised Risk Management Safety Inspection Checklist.

• Completed Risk Management Safety Inspection Checklist forms will be maintained in the "Housekeeping" binder in the ground floor supervisor's office.

• By 4/9/26 the home's administrator/supervisor(s)/housekeeping supervisor will provide education to both the home's staff and housekeeping staff on Regulation 2600.88.a to prevent future occurrences and to ensure ongoing compliance with Regulation 2600.88.a. This education will include the process of how to report missing, damaged or unsafe items for repair/replacement.

• Documentation of the staff education, including the date, length of training, instructor, and topics covered, shall be kept in accordance with Regulation 2600.65(j) and maintained in the staff meeting/training binder in the ground floor supervisor's office.

Licensee's Proposed Overall Completion Date: *04/09/2026*

Implemented [redacted] - 05/08/2026)

141b1 - Annual Medical Evaluation

6. Requirements

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

Description of Violation

Resident [redacted] most recent medical evaluation, dated [redacted], does not include a mobility needs assessment. This section of resident [redacted]s medical evaluation is blank.

Plan of Correction ***Accept [redacted] - 04/14/2026)***

Plan of Correction:

• On 4/1/26 on-site Nurse reached out to Resident [redacted] PCP to update Resident [redacted] DME to indicate the mobility needs and to check the "Independent" Mobility box.

141b1 - Annual Medical Evaluation (continued)

• On 4/1/26 Resident [redacted]s PCP approved the home's nurse to update the missed "Independent" Mobility box on the DME for Resident [redacted]

• On 4/1/26 Resident [redacted]s DME was updated by the home's nurse. Resident [redacted]s chart is now complete with all required medical evaluation information, ensuring accurate care planning and mobility support. The updated DME form was filed in Resident [redacted]s chart.

• By 4/9/26 the home's administrator/Supervisors will meet with all staff to review Regulation 2600.141.b.1. to ensure that the home's staff are aware of regulations regarding the medical evaluation being completed at least annually, to prevent future occurrences and to ensure ongoing compliance with Regulation 2600.141.b.1.

• Documentation of the staff education, including the date, length of training, instructor, and topics covered, shall be kept in accordance with Regulation 2600.65(j) and maintained in the staff chart in the supervisor's office.

• On 4/2/26 the home's administrator/Supervisors updated the DME/RASP tracker to include an additional double check process for the nurse/designated staff to review all DME's to verify that all DME sections are completed appropriately.

• The documentation of the DME/RASP checks being completed will be documented on the DME/RASP Tracker forms by the home's administrator/Supervisors/Designee.

• Completed DME/RASP tracker forms will be maintained in the supervisor's office.

Licensee's Proposed Overall Completion Date: *04/09/2026*

Implemented [redacted] - 05/08/2026)

187a - Medication Record

7. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident [redacted] January 2026 medication administration record (MAR) does not include a diagnosis or purpose for the following prescribed medications:

187a Medication Record (continued)

- [redacted]
- [redacted]
- [redacted]

REPEAT VIOLATION: [redacted] et. al.

Plan of Correction ***Accept [redacted] - 04/21/2026)***

Plan of Correction:

• On 4/1/26 Resident [redacted] s January 2026 and February 2026 medication administration records (MARs) were corrected to include the diagnosis or purpose for the following prescribed medication: Breo Ellipta 100mcg/25mg inhaler. Resident [redacted] has been hospitalized since 2/10/26, therefore there are no current MARs from March or April 2026 for Resident [redacted] When/if Resident [redacted] returns from the hospital, the MARS will reflect the diagnosis or purpose for the following prescribed medication: Breo Ellipta 100mcg/25mg inhaler.

• On 4/1/26 Resident [redacted] s January 2026 medication administration record (MAR) was corrected to include the diagnosis or purpose for the following prescribed medication: Prednisone 20mg tablet and Azithromycin 250mg. For the medication Prednisone 20mg tablet, 6 tablets were prescribed and for the medication Azithromycin 250mg tablet 10 tabs were prescribed. These medications were temporary medications and Resident [redacted] no longer takes either of these medications. As of 1/20/26, Resident [redacted] finished the prescribed course of medications for Prednisone 20mg tablet and on 1/28/26, Resident [redacted] finished the prescribed course of medications for Azithromycin 250mg tablet. On 4/7/26 the home obtained a discontinuation order for each of these medications.

• Beginning 4/1/26 the home's RNs will complete weekly Medication Cart and MAR audits to ensure that all medication entries on the MAR are complete and accurate to ensure compliance with Regulation 2600.187(a). These audits will include all current residents of the home.

• Upon completion of the weekly Medication Cart and MAR audits, the home's administrator/designee will address any identified issues. Verification of the corrections will be documented with signature by the home's administrator/Supervisor and date completed.

• Completed Medication Cart/MAR Audit forms will be maintained in the "Nursing Binder" in the ground floor supervisor's office.

• By 4/9/26 the home's administrator/Supervisor will work with the home's RNs to review and train on the process of MAR reconciliation to ensure accuracy and to ensure the RNs are aware of regulations regarding the medication administration process, including having a diagnosis or purpose listed by each medication on the MAR.

• By 4/9/26 the home's administrator/Supervisors met with all staff to review Regulation 2600.187.a. to ensure that the home's staff are aware of regulations regarding the medication administration process, including having a diagnosis or purpose for each medication listed on the MAR, to prevent future occurrences and to ensure ongoing compliance with Regulation 2600.187.a.

• Documentation of the staff education, including the date, length of training, instructor, and topics covered, shall

187a - Medication Record (continued)

be kept in accordance with Regulation 2600.65(j) and maintained in the staff meeting/training binder in the ground floor supervisor's office.

Licensee's Proposed Overall Completion Date: *04/20/2026*

Implemented (- 05/08/2026)

225c - Additional Assessment

8. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident most recent assessment, dated , does not include the diagnoses and as indicated on resident s most recent medical evaluation, dated .

REPEAT VIOLATION: , et. al.; , et. al.

Plan of Correction ***Accept - 04/14/2026)***

Plan of Correction:

• On 4/1/2026 Resident s DME attached medication list was corrected to reflect the correct purpose of the medications prescribed to Resident Pepto Bismal was listed as being taken for Dyspepsia, however this was incorrect as takes this medication for GERD. The nurse made this change on the medication list that is attached to the DME and the physician signed and dated this new medication list.

• On 4/1/26 the home's administrator/Supervisors reviewed Resident s Resident Assessment & Support Plan to ensure the correct diagnoses were indicated to reflect the diagnoses as indicated on Resident s medical evaluation, dated 4/2/25.

• On 4/1/2026 Resident DME attached medication list was corrected to reflect the correct purpose of the medication prescribed to Resident Clonazepam was listed to be taken for Anxiety; however, this was incorrect as takes this for Mental Health. The nurse made this change on the medication list that is attached to the DME and the physician signed and dated this new medication list.

• On 4/1/26, Resident s assessment and support plan was reviewed. The unlisted diagnoses on the RASP from

225c Additional Assessment (continued)

the DME attached medication list was updated and signed by the provider. The RASP now accurately reflects all diagnoses and Resident [redacted]s care is being delivered accordingly. Resident [redacted]s reviewed Resident Assessment & Support Plan was filed in Resident [redacted]s chart. The date of this review was recorded on the DME/RASP tracker form by the home's administrator/Supervisors.

• Starting 4/6/26 the home's administrator/Supervisors will utilize a DME/RASP tracker form, which includes a review column for the home's administrator/Supervisors to review all remaining resident assessments and support plans against their DME's to ensure all needs are documented, to prevent future occurrences and to ensure ongoing compliance with Regulation 2600.225c. Completed DME/RASP Tracker forms will be maintained in the supervisor's office.

• By 4/9/26 the home's administrator/Supervisor will meet with all staff to review Regulation 2600.225.c. The residents shall have additional assessments as follows: 1. Annually, to ensure that the home's staff are aware of regulations regarding the assessments being completed at least annually and that all diagnoses indicated in the DME are reflected on the assessment, to prevent future occurrences and to ensure ongoing compliance with Regulation 2600.225.c.

• Documentation of the staff education, including the date, length of training, instructor, and topics covered, shall be kept in accordance with Regulation 2600.65(j) and maintained in the staff meeting/training binder in the ground floor supervisor's office.

• Beginning 4/9/26, the home's administrator/Supervisors/designee/Senior Manager will review and compare all Resident Assessments and Support Plans against the DME on an ongoing basis and document this review for all new or updated DMEs. This will be accomplished by checking Resident Assessments and Support Plans immediately following all new or updated DMEs. The documentation of the DME/RASP checks being completed will be documented on the DME/RASP Tracker forms by the home's administrator/Supervisors/designee. Completed DME/RASP Tracker forms will be maintained in the supervisor's office.

• By 4/16/25 the home's PCHA/Supervisor/designee will have reviewed and compared all resident assessments against the DME to prevent future occurrences and to ensure compliance with Regulation 2600.225.c. These reviews will be documented on the DME/RASP Tracker forms by the home's administrator/Supervisors/designee. Completed DME/RASP Tracker forms will be maintained in the supervisor's office.

Licensee's Proposed Overall Completion Date: *04/16/2026*

225c - Additional Assessment *(continued)*

Implemented [redacted] - 05/08/2026)