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

May 20, 2026

[redacted] PRESIDENT, SECRETARY, AND TREASURER
MANOR PERSONAL CARE INC
6730 TABOR AVENUE
PHILADELPHIA, PA, 19111

RE: TABOR MANOR
6730 TABOR AVENUE
PHILADELPHIA, PA, 19111
LICENSE/COC#: 11698

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/26/2026 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: *TABOR MANOR* **License #**: *11698* **License Expiration**: *11/30/2026*

Address: *6730 TABOR AVENUE, PHILADELPHIA, PA 19111*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *MANOR PERSONAL CARE INC*

Address: *6730 TABOR AVENUE, PHILADELPHIA, PA, 19111*

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *12/01/1971* **Issued By**: *City of Phila L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *49* **Waking Staff**: *37*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/26/2026*

Inspection Dates and Department Representative

02/26/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *51* **Residents Served**: *49*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *33* **Are 60 Years of Age or Older**: *36*

Diagnosed with Mental Illness: *49* **Diagnosed with Intellectual Disability**: *4*

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

Inspections / Reviews

02/26/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/21/2026*

04/01/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/10/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/10/2026*

Inspections / Reviews *(continued)*

05/20/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/10/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

18 Compliance With Laws

1. 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

On 2/26/26 at 9:45am, there was no carbon monoxide alarm present in the basement near the boiler room or the gas stove in the main kitchen. Per the Care Facility Carbon Monoxide Alarms Standards Act of Jun. 23, 2016; Carbon Monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

On the morning of 2/26/2026, carbon monoxide detector was removed by maintenance staff to replace the batteries, resulting in a temporary absence of a required safety device.

· *On the evening of 2/26/2026,the carbon monoxide detector was reinstalled immediately after the battery replacement was completed.*

· *A functionality test was performed to ensure the detector was operating properly.*

· *All residents and staff were safe during the brief removal period.*

· *On 2/27/2026, maintenance and staff have been instructed that carbon monoxide detectors must never be removed without ensuring a temporary replacement or continuous monitoring is in place.*

· *A secondary portable CO detector will be used during the reinstallation to ensure uninterrupted safety coverage.*

· *A new written maintenance protocol has been implemented requiring:*

o *Battery replacements to be completed immediately upon removal, with no delays.*

o *A temporary backup CO detector to be used anytime a permanent detector is removed for any reason.*

· *On 2/27/2026, maintenance and direct care staff received refresher training on Regulation 2600.18 and safety device requirements.*

· *Beginning 3/1/2026, the supervisor or designee will conduct monthly safety audits to verify all CO detectors are present, functional, and properly documented. If no CO detector found it must be reported to owner and administrator immediately.*

· *Audit results will be reviewed during monthly staff meetings.*

· *Audit documentation will remain on file for 2 months then discarded.*

See attached photos

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

Implemented ([redacted] - 05/20/2026)

63a First Aid/CPR Training

2. Requirements

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

Description of Violation

On 2/19/26, 2/20/26 and 2/23/26, from 11:00pm until 7:30am, 49 residents were present in the home. During this time, no staff person was present in the home who was certified in CPR/First Aid.

63a First Aid/CPR Training *(continued)*

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

on 2/26/26, Upon discovering that the CPR card was not available at the time of survey, the Administrator immediately began investigating the issue.
It was determined that the staff member had completed CPR training but never received the emailed certification card from the trainer. on 2/26/26, The staff member was removed from the 11 7 overnight assignment until the CPR documentation was received and verified. Administrator was in contact with the trainer and the staff member until the certification card was resent.
on 2/28/26, The staff member's CPR certification was confirmed and filed in the personnel record.

The Administrator emailed the CPR card to the surveyors within a few days of the inspection.

On 3/3/2026, All staff members have been instructed to notify the Administrator immediately if certification documents are not received following any future trainings.
Also, staff were made aware they will not be scheduled for overnight shifts unless their CPR certification is verified and on file.
A CPR Certification Verification Procedure has been implemented:
All staff must confirm receipt of their CPR card within 48 hours of completing training.
If a card is not received, the Administrator will contact the trainer immediately to request reissue.
Trainers will be instructed to copy the Administrator on all emailed certification cards to ensure timely receipt.
A CPR Certification Tracking Log has been created to monitor expiration dates, documentation status, and verification of card receipt for all staff.
Staff will not be assigned to any shift requiring CPR certification unless documentation is present in their personnel file.

Beginning 4/21/2026, the supervisor or designee will conduct monthly personnel file audits for 2 months, to ensure all CPR certifications are current, documented, and accessible.
beginning July15, audits will be performed quarterly by supervisor or desinated person. Any missing or expiring certifications will be reported to the administrator and addressed immediately, with follow up documented in the tracking log.
Audit findings will be reviewed during monthly staff meetings to reinforce compliance expectations.

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

Implemented ([redacted] - 05/20/2026)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

65f Training Topics *(continued)*

3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff persons A, B and C did not receive training in medication self administration during the 2025 training year.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

• On 3/2/2026, The Administrator reviewed all training files for the 2025 training year.
• Any missing or incomplete documentation was corrected by obtaining updated training records.
• 3/3/2026, The Administrator personally provided medication self administration training to all direct care staff, ensuring every staff member received the required instruction.
• Training records have been updated, signed, and filed in each staff member's personnel file.

• As of 3/10/2026, All direct care staff have now completed the required medication self administration training for the 2026 training year.
• On 3/10/2026, The Adminsitrator verified that each staff member demonstrated competency in assisting residents with medication self administration.
• Documentation of completion is now properly maintained and available for review.

• A Training Compliance Checklist has been implemented for all annual required trainings, including medication self administration.
• The Administrator will maintain a Training Tracking Log that lists all required trainings and completion dates/times for each staff member.
• Staff will be scheduled for required trainings at least 60 days prior to the end of the training year to prevent delays or missed documentation.
• Any staff who have not completed required trainings by the scheduled deadline will be removed from direct care duties until training is completed.

• Beginning 6/2/2026, The supervisor or designee will conduct quarterly audits of personnel files to ensure all required trainings, including medication self administration, are current and properly documented.
• Audit results will be reviewed during monthly administrative meetings, and corrective actions will be taken immediately if any gaps are identified.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

82a Poisonous Materials

4. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 2/26/26 at 10:17am, a milky white liquid was observed in spray bottle in an unlocked housekeeping closet on the second floor. According to Staff Member B, the spray bottle contained concentrated Fabulouso mixed with water that the home uses for cleaning. The original product labeling was not provided by the home; however, manufacturer's instructions indicate "Keep out of reach of children, do not mix with other cleaners (especially bleach) to avoid toxic fumes, and use in well-ventilated areas."

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

2/26/26, All unlabeled bottles were immediately removed from staff use.
These bottles were replaced with manufacturer-labeled products that include proper manufacturer warnings and instructions.
The environment was checked to ensure no other unlabeled substances were present.

Only original manufacturer containers with intact labels and warnings will be used moving forward.
2/27/2026, Staff were instructed that no substances may be transferred into secondary containers unless they are properly labeled according to regulation and facility policy.

All staff were inserviced on 3/3/2026 by administrator, with trainings scheduled quarterly to ensure compliance is maintained as follows:
Proper labeling and storage of cleaning agents and toxic substances.
The prohibition of using or storing any unlabeled bottles.
Immediate reporting procedures if an unlabeled substance is discovered.
A written reminder was added to the facility's housekeeping and safety procedures.

Beginning 3/3/2026, The supervisor or designee will conduct weekly checks of all storage areas to ensure:
No unlabeled bottles are present.
All products remain in manufacturer-labeled containers.
Findings will be documented and reviewed during monthly safety meetings.
See attached photos

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

84 Heat Sources

5. Requirements

2600.

84 - Heat Sources *(continued)*

84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.

Description of Violation

On 2/26/25, baseboard heating units without covers were observed on site in the second floor shared bathroom of rooms 16-17 of the home. There were no protective guards in place to prevent residents from coming in contact with the sharp fins of the heating unit.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

On 2/28/2026, the maintenance person immediately repaired the baseboard heating units and installed the required protective guard covers.
The heating units were inspected after repair to ensure all sharp fins were fully enclosed and the units were safe for resident access.

All baseboard heating units in the facility were checked by maintanence to ensure protective covers were present and secure. All rooms found without covers were placed on a schedule for replacement. Completion date tentatively scheduled for 4/6/2026
Documentation of the repair, including date and location, was completed and filed.

A written maintenance protocol has been updated to require: to begin 4/1/2026 conducted by maintenance
Monthly inspections of all baseboard heating units for proper guard covers.
Immediate repair or replacement of any missing or damaged covers.
Documentation of each inspection and any corrective actions taken.

The owner or designee will conduct monthly environmental safety rounds, including verification that all heating units have intact protective covers.
Findings will be reviewed during monthly staff meetings to ensure accountability and ongoing compliance.

Beginning 4/4/2026 Maintenance Supervisor and owner are responsible for completing monthly inspections and ensuring repairs are made promptly.
Administrator responsible for oversight, documentation review, and ensuring staff follow safety protocols.

(see attached photos of replaced covers)

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

85a - Sanitary Conditions

6. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

At 10:15am, the shower in the shared bathroom of rooms 1/8 was observed to have dark staining and buildup within

85a - Sanitary Conditions (continued)

the grout lines and along the edges of the tile.

At 10:16am the bathroom sink in shared bathroom of rooms 1/8 was observed covered in grime and mildew was observed on the caulk behind the faucet.

At 10:23am, a strong odor of urine emanated from the shared bathroom of rooms 16-17. Upon entering the bathroom, urine was observed in the toilet bowl along with urine residue on the interior surfaces of the toilet.

On 2/26/26 at 10:24am, the shower curtain in shared bathroom 16/17 was observed to have visible rust colored staining and the metal shower curtain rings also showed visible rust and wear.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

2/27/2026, Direct care staff were notified immediately.
The shower tile and grout were deep-cleaned using disinfectant and grout-safe cleaning agents.
All staining and buildup were removed and verified by the supervisor.
The sink basin was scrubbed and sanitized to remove grime.
Mildew on the caulk behind the faucet was treated with a mildew-removal agent, romms 2-3 are scheduled to have the sink and faucets changed to include repairing the wall behind the sink. Replacement is tentatively scheduled to be completed by 4/2/2026.
The area was re-inspected and confirmed clean.

2/26/2026, direct care staff immediately cleaned and disinfected the toilet bowl and all interior surfaces.
The bathroom was deodorized and sanitized.
Staff reported they were in the middle of resident care and bathroom cleaning was scheduled immediately afterward; it appeared a resident used the toilet and did not flush.

Rust-Stained Shower Curtain & Hooks – Rooms 16–17 (10:24 AM)
Direct care staff went through the entire home, removed and replaced all shower curtains, hooks, and rods were removed and replaced with rust-proof plastic hooks and rods.
A new curtain was installed immediately.

Beginning 3/2/2026, All affected bathroom areas were deep-cleaned, sanitized, and inspected by supervisory staff.
Mildew-affected caulk areas will be monitored for recurrence and replaced if needed.
Rust-prone metal hardware has been permanently replaced with rust-proof materials.
Documentation of all corrective actions has been completed and filed.

Enhanced Cleaning Procedures
All direct care staff were inserviced on 3/3/2026
Proper grout cleaning techniques
Identifying early signs of mildew, staining, or buildup
Immediate reporting of any sanitation concerns
Staff were reminded to check and flush toilets during rounds, especially when residents may forget.
Shower Curtain Replacement Program

85a - Sanitary Conditions (continued)

Beginning April 2026, the home will implement color-coded shower curtains to ensure timely replacement.
All shower curtains will be replaced monthly by the 15th of each month.
Hooks and rods will be inspected during this replacement and replaced as needed.

Beginning 3/4/3036, Direct care staff will complete bathroom cleaning immediately after resident care to prevent odors or buildup from remaining unaddressed.
A mid-day bathroom check has been added to ensure toilets are flushed and surfaces remain sanitary.

Beginning 3/6/2026, The Supervisor or designee will conduct weekly sanitation inspections of all shared bathrooms, with documentation maintained for review.
Inspections will specifically include:
Grout lines and tile edges
Sink basins and caulk areas
Toilet cleanliness and odor checks
Shower curtains, hooks, and rods
Any deficiencies identified will be corrected immediately and logged.
Monthly administrative meetings will begin 4/3/2026 to include review of inspection logs and any corrective actions taken.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

88a - Surfaces

7. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 2/26/26 at 10:21am, rust was observed on the bathroom door frame in shared bathroom 1-8.

On 2/26/26 at 10:21am, sections of the floor tiles in rooms 1-8 were missing, leaving exposed areas of the underlying floor.

On 2/26/26 at 1:15pm, a section of wood flooring in the home's dining room was raised and not fully secured, creating an uneven floor surface.

On 2/26/26 at 1:24pm, the ceiling in resident room 19 was observed to have peeling paint and brown discoloration appearing to be water damage; also present on the wall surface in the left corner of the room.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

2/27/2026,The maintenance staff inspected the door frame and confirmed the presence of rust.

88a - Surfaces (continued)

The maintenance department has created a formal repair and replacement schedule (see attached).
The door and frame for Shared Bathroom 1–8 are scheduled to be fully replaced.
Replacement completion date: on or berfore May 31, 2026.
After replacement of all rusted door frames, the Maintenance Supervisor will conduct monthly inspections of all bathroom door frames to ensure surfaces remain intact and free of rust.
Findings will be documented on the monthly environmental checklist.

On 3/5/2026, Maintenance assessed the area and confirmed the following missing tiles in rooms 2 and 6.
The exposed area was temporarily covered to prevent tripping hazards.
Rooms 2 and 6 are the only rooms requiring full tile replacement, and these repairs are already included in the maintenance schedule to be completed on or before 4/20/2026.(see attached).

Beginning 3/2/2026, Direct care staff will conduct weekly flooring checks in all resident rooms until all repairs are completed.
Beginning and around May 20th, 2026, flooring will be monitored monthly as part of routine environmental rounds.

A section of wood flooring in the dining area was slightly raised, creating an uneven surface and potential fall hazard.

On 2/26/2026, Maintenance placed a flat-surface rug over the area as a temporary safety measure to prevent tripping.
The flooring repair has been added to the maintenance schedule (see attached).
The raised section will be secured and leveled to restore a safe, even surface.

Beginging 2/27/2026, The dining area will be checked daily by direct care staff for any additional hazards until the repair is completed.
After repair, beginning approximately May 20th, 2026, the area will be included in monthly environmental safety rounds.

Peeling Paint and Brown Discoloration – Ceiling and Wall in Room 19

2/27/2026, Maintenance inspected the ceiling for active leaks; no leaks were found at this time.
The area was marked for repair and monitored for any changes.

The ceiling and wall surfaces in Room 19 have been added to the maintenance repair schedule (see attached) with tentative completion date of 4/2/2026
Repairs will include scraping, sealing, repainting, and addressing any underlying moisture issues if discovered during the process.

2/27/2026, direct care staff will visually monitor the ceiling and wall during daily room checks until repairs are completed.
Maintenance will re-inspect the area monthly thereafter to ensure no recurrence.

Beginning 3/3/2026,the owner and Administrator will review the maintenance schedule weekly to ensure timely completion of all listed repairs.

88a - Surfaces (continued)

All corrective actions will be documented and retained for regulatory review.
on 3/3/2026, direct care staff were re-educated on promptly reporting environmental concerns to ensure timely intervention.

3/3/2026, The supervisor will check the maintenance log weekly and forward all needed reapirs in group text to include Owner, Administrator and maintenance.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

93a - Handrails

8. Requirements

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

On 2/26/26 at 10:31am, the railing descending from the second-floor emergency exit to the smoking area was observed to have its support arm broken, causing the railing to be unsecured.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

On 2/26/2026,Upon identification of the issue, the maintenance staff immediately secured the handrail and replaced the broken support arm to ensure the railing was fully stable and safe for resident use. This corrective action was completed at the time of the inspection.

On 3/6/2026, Maintenance will conduct weekly inspections of all interior and exterior handrails, with documentation maintained in the maintenance log. All emergency exit pathways, including stairways and railings, will be added to the monthly environmental safety audit.
On 3/3/2026, Direct care staff were reminded during our inservice and in the next staff meeting to immediately report any loose, damaged, or unstable handrails to maintenance and place the findings in the maintenance log.

Beginning 3/6/2026, Maintenance will be responsible for completing weekly inspections and ensuring timely repairs. The Administrator will review inspection logs monthly to verify compliance.

All systemic measures were fully implemented by 2/26/2026.
see photos

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

95 - Furniture and Equipment

9. Requirements

2600.

95 Furniture and Equipment *(continued)*

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 2/26/26 at 9:00am, surveillance cameras were observed attached to the building outside of the main entrance of the home as well as at the back of the home in the smoking section. Per interviews with staff, these cameras are not in working order.

On 2/26/26 at 10:43am, one of the two support pillars attached to the awning on the left at the entrance of the home was observed to be missing. The two pillars on the right side of the awning were observed not anchored to the ground.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

2/27/2026, Maintenance has evaluated all non operational surveillance cameras located at the main entrance and rear smoking area. The cameras have been placed on the facility's maintenance schedule for removal with tentative completion date by 4/15/2026.
No residents or staff are currently relying on these devices for safety or monitoring.

The Maintenance Department will review all exterior fixtures quarterly to ensure no non functioning or obsolete equipment remains installed on the building.
Any future installation of surveillance equipment will require administrative approval and documentation of operational status.

A tracking log will be maintained to document removal, replacement, or repair of any exterior monitoring devices.

According to the attached maintenance schedule, all cameras are scheduled to be removed no later than April 15, 2026.

The Maintenance person will oversee the removal process and ensure timely completion. The Administrator will verify compliance and maintain documentation for licensing review.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

101j1 - Mattress Fire Retardant

10. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 2/26/26, resident mattresses on site were observed to be covered with a plastic sheeting under the resident bedding.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

101j1 - Mattress Fire Retardant (continued)

On 2/26/26, immediately following the surveyor's observation that resident mattresses were covered with plastic sheeting beneath the bedding, the direct care staff conducted a full inspection of all resident beds. Any plastic sheeting or non-compliant coverings identified were removed at once. All resident mattresses were verified to be free of plastic and in compliance with regulatory requirements.

A complete audit of all resident mattresses was performed on 2/26/26 to ensure no other beds contained plastic sheeting or similar materials. No additional hazards were identified beyond those removed during the immediate correction.

The facility has updated its Housekeeping and Bedding Maintenance Procedure to explicitly prohibit the use of plastic sheeting, plastic mattress covers, or any non-breathable materials not approved by the administrator.
All direct care and housekeeping staff received re-education on 3/3/2026 by administrator, regarding proper mattress maintenance, regulatory requirements, and the risks associated with plastic sheeting.
New resident admission checklists now include a mattress compliance check to ensure no prohibited materials are introduced.

Beginning 3/6/2026, The Supervisor or designee will conduct weekly mattress inspections for four weeks, followed by monthly inspections for three months.
Findings will be documented on the Mattress Safety Audit Form and reviewed during monthly QA meetings.
Any non-compliance identified will result in immediate correction and staff retraining.

All corrective actions were completed as of 2/27/26, with ongoing monitoring as described.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

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 [redacted] bed in bedroom 14.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

2/26/2026, Immediately following the surveyor's observation, a small table was placed beside Resident [redacted] bed in Room 14 to ensure the resident has an accessible surface for personal items, in compliance with 2600.101(j)(5).

2/27/2026, A full audit of all resident rooms was conducted by direct care staff to ensure that each resident has a bedside table, shelf, or equivalent accessible surface. No additional deficiencies were identified.

101j5 - Bedside Table/Shelf (continued)

3/3/2026, Direct care staff have been instructed to verify the presence and proper placement of bedside tables or shelves during all room setup and turnover procedures.
A new item—"bedside table/shelf present and accessible"—has been added to the weekly room inspection checklist.
Staff responsible for room readiness have been re-educated on the requirements of Regulation 2600.101(j)(5).

Beginning 4/3/2026, The supervisor or designee will conduct monthly audits of a random sample of resident rooms to verify that bedside tables or shelves remain in place and accessible. Audit results will be reviewed during monthly QA meetings, and corrective action will be taken immediately if any issues are identified.

The immediate corrective action was completed on the date of the survey. Systemic measures and monitoring procedures were implemented immediately thereafter.
see photo

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

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 and Resident #3 do not have access to a source of light that can be turned on/off from bedside.

Repeat Violation Date: 2/10/25

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

Resident #2
Staff confirmed during the surveyor escort that the bedside light was operable.
2/28/2026, Maintenance replaced the light fixture and cord to ensure smooth, reliable operation.
Resident #2 now has full access to a functioning bedside light that can be independently operated.

Resident #3
Due to the current bed positioning, the wall switch was not accessible from the bedside.
2/26/26, A small light has been placed over the bed, allowing the resident to turn the light on/off independently. See attached picture
Staff verified that the resident can safely and easily operate the lamp.

2/27/2026, Maintenance and direct care staff conducted a facility-wide audit of all resident rooms to ensure each resident has access to a light source operable from the bedside.
Any rooms found with similar issues were corrected immediately.

101j7 Lighting/Operable Lamp (continued)

3/27/2026, Maintenance will check bedside lighting accessibility during all room set ups, transfers, and furniture rearrangements.
Direct care staff will verify bedside light accessibility during weekly environmental rounds.
A new line item has been added to the environmental checklist:
"Resident has access to a functioning bedside light that can be independently operated."

Beginning 3/27/2026, Maintenance or designee will audit 10 resident rooms weekly for 4 weeks, then monthly for 3 months.
Findings will be documented and reviewed during the monthly Quality Assurance & Performance Improvement (QAPI) meeting.
Any deficiencies identified will be corrected immediately, and additional training will be provided as needed.

All corrective actions were completed as of 2/28/2026.
Ongoing monitoring will continue per the schedule above.

see photo

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

13. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

There is no grab bar, hand rail or assist bar in the shower of the shared bathroom for rooms 16 17.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

On 2/28/2026, The shower was temporarily closed to ensure resident safety.
A compliant grab bar was installed on 2/28/26.
The bathroom was reopened for use once the installation was complete.
The maintenance person completed a facility wide audit of all bathrooms to verify that every shower and tub is equipped with the required grab bars.
Any missing or loose grab bars identified during the audit were corrected immediately.

Beginning 4/3/2026, Maintenance will conduct monthly bathroom safety checks, including verification of grab bar presence and stability.
The Administrator or designee will review and sign off on the monthly checklist to ensure continued compliance.

Ongoing monitoring procedures implemented as of 4/3/2026.

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface (continued)

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

Implemented ([redacted] - 05/20/2026)

102k - No Common Towel

14. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

There were no paper towels, mechanical hand dryer or other sanitary means of hand drying in the shared bathroom for rooms 16-17.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

During inspection, the shared bathroom for Rooms 16–17 did not contain paper towels or any other sanitary method for hand drying.

On 2/26/2026, direct care staff immediately replaced paper towels and hand soap during the cleaning process. Verification was made by supervisor that Rooms 16–17 have in room sinks equipped with hand soap and hand towels for resident use.
It is protoccol for staff to replenish paper towels, soap, and toilet paper daily, while performing room cleanings.

On 3/3/2026, Both 7–3 and 3–11 shifts have been inserviced by administrator on the requirement to check all resident rooms and all community bathrooms for:
o Paper towels
o Hand soap
o Toilet paper
• Staff were instructed on proper documentation and reporting procedures if supplies are missing or low.
•Beginning 3/3/2026, Direct care staff will complete twice daily supply checks for all bathrooms and resident rooms. Beginning 3/3/2026, The Supervisor or designee will conduct weekly audits to ensure all handwashing areas remain fully stocked.
• The Administrator will review and sign off on weekly audit sheets to ensure continued compliance.

• Immediate corrective action completed on 2/26/2026.
• Ongoing monitoring procedures implemented as of 3/3/2026

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

103e - Left Overs

15. Requirements

103e Left Overs *(continued)*

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 2/26/26 at 9:07am, boxes of unlabeled/undated Fruity Pebbles and Fruit Loops and a bag of unlabeled/undated marshmallows were observed in the main pantry.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

During the annual inspection on 2/26/26, unlabeled and undated boxes of Fruity Pebbles, Fruit Loops, and an unlabeled bag of marshmallows were observed in the main pantry.

on 2/26/2026, all unlabeled and undated food items were immediately discarded during the annual inspection. Additionally, The pantry was checked to ensure no additional unlabeled items were present.

Beginning 3/2/2026, Staff will ensure that all food items are labeled and dated before being stored in the pantry or refrigerator.
Only properly labeled, sealed, and identifiable food items will be permitted in storage areas.

The administrator inserviced all staff on 3/3/2026 as follows:
Proper labeling and dating procedures for all food items.
The requirement that no food may be stored without a clear label and date.
Immediate reporting procedures if an unlabeled item is found.
Updated written procedures were added to the kitchen and pantry guidelines.

Beginning 3/6/2026, The supervisor or designee will conduct weekly pantry and refrigerator checks to ensure:
All food items are properly labeled and dated.
No unlabeled or expired items are present.
Findings will be documented and reviewed during monthly safety and sanitation meetings.

Administrator and supervisor are responsible for weekly monitoring and staff reinforcement.
Administrator responsible for oversight, training, and ensuring continued compliance.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

103f Refrigerator/Freezer Temps

16. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 2/26/26 at 9:09am, there was no thermometer inside of the basement chest freezer.

103f Refrigerator/Freezer Temps *(continued)*

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

On 2/26/2026, Upon discovery during the annual survey, kitchen staff located the thermometer at the bottom of the chest freezer.
A freezer basket was installed in the chest freezer, and the thermometer was secured to hang from the basket, ensuring it is visible and easily accessible for temperature checks. (see photos)

The thermometer will remain properly positioned in the freezer basket to allow staff to read temperatures without reaching into the bottom of the freezer.
Staff will continue to perform routine temperature checks and verify that the thermometer remains in its designated location.

The administrator re educated all kitchen staff On 3/3/2026, staff were reminded of the requirement that every freezer must contain a clearly visible and reachable thermometer.
Staff were instructed to immediately report if a thermometer is missing, damaged, or not easily accessible.
A freezer specific labeling reminder was added to the kitchen's temperature monitoring procedures.

Beginning 3/4/3036, The supervisor or designee will conduct weekly checks of all refrigerators and freezers to ensure:
A thermometer is present
The thermometer is visible and reachable
Temperatures are being recorded as required
Monitoring results will be documented and reviewed during monthly safety and sanitation meetings.

Kitchen staff are responsible for daily temperature checks and ensuring thermometer placement.
The supervisor is responsible for weekly oversight, documentation review, and ensuring continued compliance.
The supervisor will promptly report to the Administrator with any issues.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

107c - Food/Water 3 Day Supply

17. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 2/26/26, the home had served 49 residents, requiring 147 gallons of emergency drinking water; however, the home had only 145 gallons of emergency drinking water. The home does not have a contract with a local bottled water supplier that includes emergency delivery within 24 hours.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

Emergency Drinking Water Supply

On 2/26/2026, the home had 49 residents, requiring 147 gallons of emergency drinking water to meet the three day supply requirement. At the time of inspection, the home had 145 gallons, resulting in a 2 gallon shortage.

107c Food/Water 3 Day Supply (continued)

On 2/27/2026, the home purchased 48 additional gallons of emergency drinking water. This action ensured the home exceeded the required three day supply for all residents.

Beginning on or about 3/6/2026, the supervisor or designated staff person will:
Conduct weekly checks of the emergency drinking water supply.
Document the total gallons present on the Emergency Supply Log.
Sign and date each weekly entry.
Immediately report any discrepancies to the Owner and Administrator for corrective action.

Beginning 4/3/2026, the Administrator will review the weekly Emergency Supply Log monthly to verify accuracy, ensure the required supply is consistently maintained, and confirm that any discrepancies were addressed promptly.

All corrective actions were initiated on 2/27/2026 and the home is currently in full compliance.

See attached photos

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

107d - Procedure Emergency Management Agency Submission

18. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home could not provide proof that their written emergency procedures were submitted annually to the local emergency management agency since 2024.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

During the annual inspection, the home was unable to provide proof that its written emergency procedures were submitted annually to the local Office of Emergency Management (OEM) since 2024. Although the owner submits the procedures via email each year, confirmation of receipt had not been obtained or documented.

The owner provided the email evidence showing that the written emergency procedures were submitted to OEM on the following dates: see attached confirmation
March 5, 2024
February 10, 2025
March 4, 2026
These emails confirm that the home has consistently attempted to meet the annual submission requirement.

To ensure ongoing compliance and verifiable documentation Beginning 1/1/2027, the owner will:
Continue to submit the written emergency procedures annually via email to OEM.
Request written confirmation of receipt from OEM with each submission.

107d Procedure Emergency Management Agency Submission (continued)

If confirmation is not received within 10 business days, the owner will:
Follow up with OEM via a second email, and
If needed, follow up by phone to obtain written verification.
All submissions and confirmations will be printed and filed in the Emergency Preparedness Binder and saved electronically in the Emergency Procedures folder.

Beginning 1/1/2027, The Administrator will:
Review the Emergency Preparedness Binder annually each February to ensure the submission and confirmation are present.
Document the review on the Emergency Preparedness Annual Checklist.
Report any missing documentation to the Owner immediately for corrective action.

Corrective actions were initiated on March 4, 2026, and the home is currently in compliance.

see attached email confirmation of the home sending the annual updates for 2024, 2025 and 2026.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

132g - Fire Drills Days/Times

19. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills at the end of the month as evidenced by the following drills: 1/28/26; 11/30/25; 10/31/25; 9/29/25; 8/29/25; 7/31/25.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

Fire Drills Timing and Distribution Throughout the Month

During the annual inspection, it was identified that the home routinely conducts fire drills at the end of the month, rather than distributing them throughout the month as required. This pattern was evidenced by the following drill dates:
January 28, 2026
November 20, 2025
October 31, 2025
September 29, 2025
August 29, 2025
July 31, 2025
This pattern does not meet the regulatory requirement for drills to occur at varied times throughout the month.

132g - Fire Drills Days/Times (continued)

On 3/6/2026, the Administrator immediately notified the fire safety corporation responsible for conducting the home's fire drills. The Administrator informed them of the regulatory violation and directed them to adjust scheduling practices to ensure drills are conducted at varied times throughout each month.Supporting documentation has been attached.

Beginning April 2026, The Administrator will provide the fire safety corporation with a monthly scheduling window that requires drills to occur no earlier than the 1st and no later than the 20th of each month, with the specific date varying month to month.

The Administrator will require the fire safety corporation to submit the planned drill date in advance for approval. If a drill is not completed by the approved date, the Administrator will immediately reschedule it to ensure it does not default to the end of the month.
All drill dates will be logged, reviewed, and filed in the Fire Safety Binder.

Beginning April 2026, the Administrator or designee will:
Review the fire drill schedule monthly to ensure the drill date varies and does not fall at the end of the month.
Document the review on the Fire Drill Monthly Audit Log.
Report any deviation immediately to the fire safety corporation and the Owner for corrective action.

Corrective actions were initiated on March 26, 2026, and the home is currently in compliance.

See attached communication letter received from the Fire Safety Company

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented (- 05/20/2026)

141a - Medical Evaluation

20. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #4 was admitted on [redacted] The resident's medical evaluation was not completed until [redacted]

Plan of Correction ***Accept (- 04/01/2026)***

Resident: #4
Admission Date: [redacted]
Medical Evaluation Completion Date: [redacted]

141a - Medical Evaluation (continued)

Resident #4 was admitted to the home on [redacted]. Upon admission, the Administrator identified that the resident's medical evaluation had been completed on an incorrect form. Multiple attempts were made to contact the resident's physician at [redacted] to obtain the correct medical evaluation form. The facility was informed that the resident would need to schedule an appointment for the correct form to be completed. The next available appointment was not until [redacted], resulting in the medical evaluation not being completed within the required timeframe.

The Administrator made several attempts to contact the physician at [redacted] to obtain the correct medical evaluation form.
The resident was informed of the need to schedule an appointment with the physician to complete the correct form.
The resident later requested to change [redacted] primary care physician to the in-house physician who visits the home.
On [redacted], the in-house physician evaluated Resident #4 and completed the correct medical evaluation form.
The completed and signed medical evaluation was placed in the resident's record, bringing the resident into compliance.

The Administrator and Supervisor will review all medical evaluations prior to or at the time of admission to ensure:
The correct form is used
All required sections are completed
The evaluation is signed and dated by a licensed physician
If a medical evaluation is found to be incomplete or on an incorrect form, the Administrator will:
Contact the physician's office within 24 hours
Document all communication attempts
Residents experiencing difficulty obtaining timely documentation from an outside physician will be offered assistance in transitioning to the facility's in-house physician to prevent delays.

The Administrator or designee will conduct weekly audits of all new admissions for 90 days to verify that medical evaluations are complete, on the correct form, and signed.
After 90 days, audits will continue monthly as part of the facility's quality assurance process.
Any identified issues will be corrected immediately and reviewed during administrative meetings.
Administrator is resposible for oversight of admission documentation, physician communication, and regulatory compliance.
Supervisor is resposible for erification of completed medical evaluations and documentation follow-up.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

144c1 - Smoking Area Guidelines

21. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

144c1 - Smoking Area Guidelines *(continued)*

Description of Violation

The home's smoking area is located on the back patio. On 2/26/26, approximately 25 cigarette butts were observed thrown in the snow at the entrance of the home and approximately 40 cigarette butts were observed thrown in the snow in the home's yard.

Plan of Correction ***Accept (- 04/01/2026)***

Smoking Area & Disposal of Cigarette Butts

On 2/27/2026, a meeting was held with all residents and staff to inform them of the violation and to reiterate the home's smoking policy. See attached resident sign-in sheet
Residents were instructed that smoking is prohibited in the front of the home, on the sides of the home, and in the yard.
Residents were reminded that smoking is permitted only on the back patio and that all cigarettes must be fully extinguished and disposed of only in the provided receptacles.
Staff immediately cleaned and removed all cigarette butts from the entrance and yard.

Beginning 3/4/2026, Direct care staff on all shifts, except the 11 p.m.–7 a.m. shift, will conduct two cigarette-butt checks per shift in the smoking area and surrounding grounds.
Any cigarette butts found outside the designated smoking area will be removed immediately, and the incident will be documented.
Residents will continue to receive weekly reminders during community meetings regarding proper smoking locations and disposal requirements.
Additional signage will be posted reinforcing:
"Smoking Permitted on Back Patio Only"
"Dispose of Cigarettes in Designated Receptacles Only"

Beginning 3/6/2026, The Administrator or designee will review the shift cigarette-butt check logs weekly to ensure compliance with the monitoring schedule.
Any repeated concerns will be addressed promptly with staff and residents, including retraining or corrective counseling as needed.
Compliance will be reviewed during monthly safety rounds.

All corrective actions were initiated on 2/27/2026 and full implementation of the monitoring plan will be completed by 3/2/2026.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented (- 05/20/2026)

183e - Storing Medications

22. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

183e Storing Medications *(continued)*

Description of Violation

At 11:40am, two white round pills were observed loose in the bottom of the home's medication cart.

A bottle of Nystop Nystatin topical powder was observed in the home's medication cart for Resident #1. This medication had an expiration date printed on the bottle of 12/31/25. A second bottle of Miconazorb Powder was found in the medication cart for Resident #1. The pharmacy label indicated that this powder expired 8/24/23.

Resident #5's Gaviscon extra strength blister pack was observed to have a punctured blister foil with the medication still present in the spot exposing it to contamination or improper sanitation.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

Medication Storage, Sanitation, and Expiration Control

During Inspection on 2/26/2026, the expired bottles of Nystop and Miconazorb powder were immediately discarded by Supervisor
Replacement bottles were already available in the home and placed into use.
The punctured Gaviscon blister for Resident #5 was discarded due to potential contamination Immediately after the inspection.
On 2/27/2026, the supervisor checked the entire medication cart for any additional loose pills, and none were found.
On 2/26/26, The loose pills observed at the bottom of the cart were removed and discarded.

Beginning 3/28/2026, the following procedures will be implemented:
The medication technician will clean the medication cart weekly, removing all medications from each drawer, wiping out the drawer, and inspecting for:
Loose pills
Damaged packaging
Expired or soon to expire medications
Contaminated or improperly stored items
After inspection and cleaning, the medication technician will return medications to their designated slots before moving to the next drawer.
The 7 3 medication technician will complete and sign a weekly Medication Cart Cleaning & Inspection Log documenting:
Drawer by drawer cleaning
Expiration date checks
Removal of any compromised medications
Reordering of discarded or soon to expired medications as needed
Any medication found to be expired, damaged, or exposed will be immediately discarded, and replacement medication will be reordered the same day. This information will be documented and provided to administrator or designee to view every Tuesday

Beginnning 3/31 The Administrator or designee will review the weekly cleaning log every Tuesday to ensure the task was completed and documented.
Beginning 4/2026, Random spot checks of the medication cart will be conducted twice monthly for the next 90 days, then monthly thereafter.

183e - Storing Medications (continued)

Any discrepancies will be addressed immediately with retraining and corrective action as appropriate.

All immediate corrective actions were completed on 2/28/2026.
The ongoing weekly cleaning and monitoring process will begin 3/28/2026 and continue indefinitely.
See attached inservice (med Techs)

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)

184b - Labeling OTC/CAM

23. Requirements

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

Description of Violation

Bottles of Antacid, Acetaminophen 325mg, Geri-Care- One Daily Multivitamin, Colace, Allergy Relief and Nature Made Energy B-12-1000mg were observed in the home's medication cart. They were not labeled with a resident name or room number. An interview with Staff Member C indicated that these medications were kept as house stock, but were opened and reported to be used for more than one resident.

Plan of Correction ***Accept ([redacted] - 04/01/2026)***

On 2/26/2026, All unlabeled OTC medications found in the medication cart were immediately discarded by medication tech on duty.
Additionally, The medication cart was inspected in full to ensure no additional house-stock medications were present.
On 2/26/2026, Staff Member C and all medication technicians were verbally redirected at the time of discovery regarding the prohibition of house-stock medications.
The deficiency occurred due to a misunderstanding among medication technicians regarding the use of OTC medications and the belief that certain items could be kept as shared house stock. Staff were not consistently following the requirement that all medications must be resident-specific, labeled, and used only for the individual for whom they were ordered.

On 3/4/2026, all medication technicians received retraining on Regulation 2600.184(b), conducted by Administrator, including:
House stock medications are prohibited in personal care homes.
All OTC medications must be prescribed or approved for a specific resident, labeled with the resident's name and room number, and stored accordingly.
Medications may not be shared between residents under any circumstances.
The Medication Storage & Handling Policy was updated and redistributed to all med-techs, with emphasis on OTC labeling and resident-specific use.

Beginning 3/10/2026, the Administrator or designee will conduct weekly medication cart audits for 12 weeks to ensure:
No OTC medications are present unless labeled for a specific resident.
No house-stock medications are stored or used.

184b - Labeling OTC/CAM (continued)

After the 12-week monitoring period, audits will continue monthly as part of ongoing compliance.
Any staff found storing or using house-stock medications will receive immediate corrective coaching and, if repeated, progressive disciplinary action.

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Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented ([redacted] - 05/20/2026)