**Department of Human Services**
**Bureau of Human Service Licensing**

# LICENSING INSPECTION SUMMARY - PUBLIC

May 18, 2026

[REDACTED], OWNER
SHELLEY R. SMITH
5224-26 NORTH BROAD STREET
PHILADELPHIA, PA, 19141

RE: BROAD STREET RESIDENCE
5224-26 NORTH BROAD STREET
PHILADELPHIA, PA, 19141
LICENSE/COC#: 17636

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/02/2026, 03/03/2026 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**: *BROAD STREET RESIDENCE* **License #**: *17636* **License Expiration**: *10/01/2026*

**Address**: *5224 26 NORTH BROAD STREET, PHILADELPHIA, PA 19141*

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

## Administrator

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

## Legal Entity

**Name**: *SHELLEY R. SMITH*

**Address**: *5224-26 NORTH BROAD STREET, PHILADELPHIA, PA, 19141*

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

## Certificate(s) of Occupancy

**Type**: *I-1* **Date**: *08/02/1991* **Issued By**: *City of Philadelphia*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *23* **Waking Staff**: *17*

## Inspection Information

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

**Reason**: *Renewal* **Exit Conference Date**: *03/03/2026*

## Inspection Dates and Department Representative

*03/02/2026 - On-Site:* [redacted]

*03/03/2026 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *24* **Residents Served**: *23*

### Secured Dementia Care Unit

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

### Hospice

**Current Residents**: *0*

### Number of Residents Who:

**Receive Supplemental Security Income**: *14* **Are 60 Years of Age or Older**: *17*

**Diagnosed with Mental Illness**: *23* **Diagnosed with Intellectual Disability**: *4*

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

## Inspections / Reviews

### 03/02/2026 Full

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/05/2026*

### 04/14/2026 - POC Submission

**Submitted By**: [redacted] **Date Submitted**: *05/15/2026*

**Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/16/2026*

## Inspections / Reviews *(continued)*

### 05/08/2026 POC Submission

**Submitted By**: [redacted] **Date Submitted**: *05/15/2026*

**Reviewer**: [redacted] **Follow Up Type**: *Document Submission* **Follow Up Date**: *05/10/2026*

### 05/18/2026 Document Submission

**Submitted By**: [redacted] **Date Submitted**: *05/15/2026*

**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**

*The Carbon Monoxide detector for the kitchen which used gas in their equipment was not operable and was within 15 feet of the gas stove. 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 (█ - 04/14/2026)***

*On March 5, 2026 - with 24-28 hours of citation, the non-operable carbon monoxide detector located near the kitchen was immediately replaced with a new, fully functional unit.*
*The new carbon monoxide detector wads installed in compliance with the law, ensuring it is located in proximity to but not less than 15 feet from the gas stove.*
*The newly installed unit was tested and confirmed to be fully operational at the time of installation.*
*Installation of the replacement and testing has been documented in the appropriate policy binder.*

***Steps to Prevent Recurrence:***

*1. The administrator conducted a complete inspection of all carbon monoxide detectors throughout the building to ensure proper placement and functionality.*
*2. A quarterly log has been implemented to test all carbon monoxide detectors. Batteries will be replaced as needed and documented.*

***Monitoring for Compliance:***

*1. Effective, March 15, 2026, the administration will perform monthly visual audit through May 30, 2026 of all detectors to ensure proper function and maintain on-going compliance. Any issues will be corrected immediately and findings will be documented and reviewed internally for continuous improvement purposes.*

**Licensee's Proposed Overall Completion Date:** *04/01/2026*

***Implemented (█ - 05/18/2026)***

## 20b5 - No Commingling

**2. Requirements**

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
5. Commingling of resident funds and home funds is prohibited.

**Description of Violation**

*On 1/27/2025, 2/26/2025, 3/23/2025, 4/23/2025, 5/23/2025, 6/25/2025, 7/24/2025, 8/25/2025, 9/24/2025, 10/24/2025, 11/26/2025, and 12/23/2025, funds belonging to residents #1, #2, #3, #4, and #5 were commingled in an account owned by the home's business entity.*

*On 6/7/2025, 7/9/2025, 8/8/2025, 9/9/2025, and 10/7/2025, funds belonging to resident #6 were commingled in an*

## *20b5 - No Commingling (continued)*

*account owned by the home's business entity.*

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

*In response to the violation on 3/2/2026, immediate action was taken on 3/5/26 by the administrator to review all resident financial accounts.*

*To enhance the currently compliant operations, effective 1/1/26, the administrator no longer transfers resident funds to the "resident spending account" which is owned by the homes' legal entity. Resident PNA's are now withdrawn each month directly from each resident account individually. Each resident's current balance has been verified and reconciled to ensure accuracy. This action will be verified on the residents quarterly review of their bank statement, with a completion date of 4/30/26.*

*Effective April 1, 2026 the administrator will perform quarterly reviews thru June 30, 2026 to maintain ongoing compliance along with a reconciliation of all financial resident accounts to ensure no comingling of funds and accurate balances. Any deficiencies will be corrected immediately and finding will be documented and reviewed internally for continuous improvement purposes.*

**Licensee's Proposed Overall Completion Date:** *04/30/2026*

***Implemented (█ - 05/18/2026)***

## 26b - Quality Management Plan Content

**3. Requirements**

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

**Description of Violation**

*The home does not have resident council meetings minutes for 2025.*

**Plan of Correction** ***Directed (█ - 05/08/2026)***

*The Broad Street Residence respectfully submits that this citation may have been issued in error based on the following:*

*The home does has never in the past nor currently have a Resident Council or Family Council.*
*Per 55 Pa. Code 2600.26(b)(5), the regulation states:*
*"Resident or family council, or both, if applicable".*
*The regulation does not mandate that a resident council must be established; therefore, maintaining meeting minutes is only required if such a council exists.*

## *26b - Quality Management Plan Content (continued)*

*This was explaining during the inspection to the inspectors. The home maintain that participation in a resident council is resident-driven and optional, and not a regulatory requirement.*

*While maintaining that the citation may not apply, the home has taken proactive steps in good faith to strengthen resident engagement:*

*Moving forward, the facility will continue to host informal resident meetings periodically and will encourage communication and participation.*

*If a resident council is established in the future, the facility will:*

*Conduct regular meetings*
*Maintain meeting minutes*
*Incorporate outcomes into the quality management plan.*

***Directed***

*Within 30 days of receipt of the accepted plan of correction – The home will develop and implement a quality management plan that includes all of the required components of 2600.26b. Documentation will be kept.* ██

*Proposed Overall Completion Date: 05/07/2026*

**Directed Completion Date:** *05/07/2026*

***Implemented (██ - 05/18/2026)***

## 85a - Sanitary Conditions

**4. Requirements**

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

**Description of Violation**

*On 3/2/2026, the following were observed:*

- *At approximately 9:30 am, the air conditioning unit in the 3rd floor hallway attached to the ceiling on 5226 side had an accumulation of dust on the wires.*
- *At 9:47 am, 5224-3rd floor shared bathroom has a bathmat in the shower.*
- *At 9:56 am, 5224-2nd floor shared bathroom has a bathmat in the shower.*
- *At approximately 10:00 am, resident room number 3 on 5224-2nd floor has a portable box fan with an accumulation of dust on the blades and grille.*
- *At 10:32 am, 5226- 2nd floor shared bathroom has a bathmat in the shower.*

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

*On March 5, 2026, immediately following the inspection:*

*1. The air conditioning unit on the 3rd floor hallway (5226 side) was cleaned, and all dust was removed from wires and surrounding areas.*

## *85a - Sanitary Conditions (continued)*

*2. The portable box fan in resident room #3 was thoroughly cleaned, including blades and grille.*
*3. The bathmats were removed from both shared showers to eliminate unsanitary conditions and reduce risk of mold and bacteria buildup.*
*4. Staff were notified and re-instructed on proper sanitation expectations.*

***To Prevent Recurrence***
*The daily and weekly cleaning schedule has been implemented which includes:*
*Cleaning of fans, vents and air conditioning units.*
*Daily inspection and cleaning of all shared bathrooms.*
*Prohibition of bathmats inside showers ~~unless they are non-porous and disinfected after each use.~~*
*Staff Training:*
*All staff will be re-training by April 17, 2026 on:*
*Proper infection control and sanitation practices*
*Identification of dust accumulation and unsanitary conditions*
*Bathroom hygiene standards and safe equipment usage.*

***Monitoring for Compliance***
*The administrator will conduct a monthly walk-thru of the home to identify and unsanitary and unclean areas. All issues will be immediately corrected and findings will be documented and reviewed internally for continuous improvement purposes.*

*Proposed Overall Completion Date: 04/01/2026*

**Licensee's Proposed Overall Completion Date:** *04/01/2026*

***Implemented (█ - 05/18/2026)***

## 87 - Lighting

**5. Requirements**

2600.
87. Lighting - The home's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

**Description of Violation**

*On 3/2/2026, the overhead light in resident room number 12 on the 3rd floor was observed to be inoperable.*

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

*ON March 5, 2026, the overhead light in resident room #12 was replaced and restored to full working condition. The fixture was tested to ensure proper illumination and safe operation.*

*Staff have been instructed to report any inoperable lighting immediately to the administrator.*

## *87 Lighting (continued)*

*The administrator will conduct weekly walk thru to verify that all lighting fixtures are operational. Any lighting issues will be identified and addressed immediately.*

**Licensee's Proposed Overall Completion Date:** *04/01/2026*

***Implemented (█ - 05/18/2026)***

## 88a - Surfaces

**6. 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 3/2/2026 the following were observed:*

- *The ceiling tiles in shared bathroom on 5224 2nd floor shared bathroom were stained with a brown substance.*
- *The entrance to the dining room has a raised lip measuring approximately 0.25 0.50 inches in height, which may cause a tripping hazard.*

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

*On March 7, 2026, the stained ceiling tiles in the shared bathroom were removed and replaced with clean, new tiles.*
*The area above the ceiling tiles was inspected to ensure there were no active leaks or moisture issues, and none were found.*
*The raised lip at the entrance to the dining room has had a floor leveler installed by the contractor. This has eliminated the tripping hazard.*
*Periodically, the administrator will perform a walk thru to identify any and all tripping hazards, and ceiling tiles that may need repairing. Any issues found will be repaired within 48 hours.*
*Staff have been reminded to:*
*Identify hazards (stains, uneven flooring, etc.)*
*Report maintenance issues immediately*

**Licensee's Proposed Overall Completion Date:** *04/03/2026*

***Implemented (█ - 05/18/2026)***

## 89b - Hot Water Temperature

**7. Requirements**

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

**Description of Violation**

*On 3/2/2026, at approximately 9:35 am, the hot water temperature at the bathroom sink in 5226 3rd floor*

## *89b - Hot Water Temperature (continued)*

*measured 123.6 degrees Fahrenheit.*

*On 3/2/2026, at approximately 9:29 am, the hot water temperature at the bathroom sink in 5224-2nd floor measured 129.7 degrees Fahrenheit.*

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

*Immediately following the inspection:*

*The facility's hot water heater as adjusted to reduce overall water temperature to within the safe and compliant range.*

*Both affected sinks were re-tested after adjustment and confirmed to be within acceptable temperature limits.*

*Staff were instructed to monitor resident use of hot water until compliance was verified to prevent risk of burns.*

***Routine Temperature Monitoring***:

*All staff have been re-instructed to complete the hot water temperature log, checking temperatures at multiple sinks and bathing areas, recording temperatures at least weekly. Each staff has been assigned a particular day during the week.*

*The administrator will conduct a monthly review of the setting on the hot water tank to ensure proper placement.*

***Staff Training - Staff will be re-trained by April 17. 2026 on:***

*Safe water temperature ranges*

*How to test water temperature using a thermometer*

*Immediate reporting procedures for out-of-range temperatures*

***Monitoring for Compliance:***

*Weekly water temperatures will be documented by staff using the Hot Water Temperature Log*

*The administrator will review logs monthly to ensure compliance and identify any trends.*

*Any temperature above 120 F will be corrected immediately, and the issue will be documented and re-tested the same day.*

**Licensee's Proposed Overall Completion Date:** *04/06/2026*

***Implemented (█ - 05/18/2026)***

## 91 - Telephone Numbers

**8. Requirements**

## 91 Telephone Numbers *(continued)*

2600.
91. Emergency Telephone Numbers Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

**Description of Violation**

*There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in bedroom number 8.*

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

*The facility maintains a designated resident telephone with an outside line, and all required emergency telephone numbers are clearly posted at that location, in full compliance with 2600.91.*
*Several residents (including the resident in bedroom #8) utilize a personal cell phone.*
*The regulation states that emergency numbers must be posted "on or by each telephone with an outside line"; it does not specifically address or require postings for privately owned personal cell phones.*
*The home respectfully requests consideration that the regulation specifically applies to telephones with outside lines and does not explicitly reference privately owned cellular devices. However, the home has taken proactive steps beyond the refulation to ensure resident safety and full compliance.*

***Corrective Action****:*
*On March 6, 2026, in good faith and to ensure full compliance moving forward:*
*An Emergency Telephone Numbers sheet was posted in resident bedroom #8.*

***Steps to Prevent Recurrence:***
*Emergency numbers have been placed in all resident bedrooms, regardless of whether residents use personal cell phones.*

***Monitoring:***
*Staff will do a visual check when performing housekeeping to ensure emergency numbers are posted in bedrooms.*
*Any missing postings will be reported to the administrator for immediate correction.*

**Licensee's Proposed Overall Completion Date:** *04/06/2026*

***Implemented (█ - 05/18/2026)***

## 95 Furniture and Equipment

**9. Requirements**

2600.
95. Furniture and Equipment Furniture and equipment must be in good repair, clean and free of hazards.

**Description of Violation**

*On 3/2/2026, a dining room chair used by residents was observed with a torn upholstery.*

*On 3/2/2026, a dresser in resident bedroom number 3 on 5224 -2nd floor was observed to have missing drawers, and some drawers were off the rails.*

## 95 Furniture and Equipment *(continued)*

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

*Immediately following the inspection, the dining room chair with torn upholstery was replaced with a new chair.*
*The dresser in resident bedroom #3 was removed and replaced with a safe, fully function dresser.*
*All replacements were inspected to ensure cleanliness, safety and in good repair.*

*The administrator conducted a facility wide inspection of all resident furniture to identify and address any additional issues.*
*Staff will weekly identify and bedroom items needing replacement or repair and report same to the administrator.*
*Any furniture found to be damaged, torn, or unsafe will be:*

*Removed immediately from use*
*Repaired or replaced within 24 72 hour, depending on severity*

*Administrator will conduct a quarterly visual audit of all bedrooms and common areas to ensure compliance.*

**Licensee's Proposed Overall Completion Date:** *04/06/2026*

***Implemented (█ - 05/18/2026)***

## 96a - First Aid Kit

**10. Requirements**

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

**Description of Violation**

*The first aid kit in the medication room contained antiseptic that expired on 9/3/2022.*

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

*Immediately following the inspection, on March 5, 2026, the expired antiseptic was removed ad discarded.*
*The item was replaced with a new, unexpired antiseptic.*
*The entire first aid kit was reviewed to ensure all required items were present.*

*Staff have been assigned to inspect the kit at the beginning of each month to identify any items needing replacement.*

*Periodically the administrator will perform a check of the first aid kit to ensure on going compliance.*
*Any expired or missing items will be immediately replaced.*

## 96a First Aid Kit *(continued)*

**Licensee's Proposed Overall Completion Date:** *04/06/2026*

***Implemented ( - 05/18/2026)***

## 101j7 - Lighting/Operable Lamp

**11. 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 bedroom number 8 on 5226 2nd floor does not have access to a source of light that can be turned on/off at bedside.*

*Repeat Violation: 2/20/2025*

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

*The facility did provide an operable bedside lamp to resident #8, placed appropriately on the resident's nightstand.*
*The resident exercised personal choice and autonomy by removing the lamp and replacing it with a television on the nightstand.*
*The staff and administrators educated the resident on the safety requirement for bedside lighting, including fall prevention and regulatory compliance.*
*The resident acknowledged understanding the need for bedside lighting.*

*After further discussion, the resident agreed to keep the bedside lamp accessible and understands the importance of maintaining it for safety.*
***Immediate Corrective Action***:
*On March 6, 2026, staff ensured that:*
*The bedside lamp was returned to an accessible position within reach of the resident's bed.*
*The lam was tested and confirmed to be fully operable.*
***To Prevent Recurrence***:
*Residents will be educated upon admission and as needed regarding required safety equipment, including bedside lighting.*
*Staff will verify during routine room checks that all required furnishing, including bedside lamps, are present and accessible.*
*Monitoring for Compliance:*
*Staff will conduct weekly inspections of resident rooms to ensure bedside lighting is present and functional.*
*The administrator will perform quarterly walk thru to ensure ongoing compliance. If a bedside lamp is found missing or inaccessible, the lamp will be repositioned/replaced immediately and resident will be re educated as needed.*

**Licensee's Proposed Overall Completion Date:** *04/07/2026*

***Implemented ( - 05/18/2026)***

## 101o - Walls, Floors, Ceilings

**12. Requirements**

2600.

## 101o - Walls, Floors, Ceilings *(continued)*

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

**Description of Violation**

*The paint on the ceiling and wall in bedroom number 3 is peeling.*

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

*On March 6, 2026:*

*The affected areas in resident bedroom #3 were assessed for damage and safety concerns.*

*Loose and peeling paint was removed to eliminate any immediate hazard.*

*The area was scheduled for repair and repainting.*

*The ceiling and wall in bedroom #3 will be properly repaired, patched and repainted using appropriate materials by March 20th.*

***Monitoring***:

*The area will be inspected for any underlying causes (e.g. moisture, leaks, etc.) to prevent future peeling. Any identified issues will be addressed promptly.*

*During routine housekeeping, staff will identify and signs of peeling paint on walls and ceilings.*

*Issues will be reported to the administrator in writing.*

*Ensure resident living areas remain safe and in good repair.*

*The administrator will upon notification, will schedule the area for repair/repainting.*

***Compliance:***

*The administrator will perform a periodic thru-thru of resident living areas to observe deterioration (e.g. peeling paint, cracks, etc.). Any areas requiring repair will be addressed within 72 hours depending on severity.*

**Licensee's Proposed Overall Completion Date:** *04/07/2026*

***Implemented ( - 05/18/2026)***

## 101r - Bedroom - shades/drapes/window covering

**13. Requirements**

2600.

101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

**Description of Violation**

*The window in bedroom number 8 blinds were broken.*

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

*Immediately following inspection, the broken blind was removed from bedroom #8.*

*On March 4, 2026, new blinds were installed and tested to ensure they are fully functional and provide proper privacy and light control.*

***Steps to prevent recurrence:***

*The administrator conducted a facility-wide walk-thru of all bedroom windows to ensure blinds and window coverings are intact and operational.*

***Preventive Measures:***

## 101r Bedroom shades/drapes/window covering (continued)

*During routine daily housekeeping, staff have been instructed to observe and report in writing to the administrator, any broken blinds needing repair.*
*Damaged or broken blinds will be:*
*reported immediaely*
*repaired or replaced within 24 72 hours*

***Monitoring**:*
*Administrator will conduct a quarterly walk thru of resident rooms to ensure window coverings remain intact and functional.*
*Any broken or missing window coverings will be addressed immediately with temporary coverage and replaced promtly.*

**Licensee's Proposed Overall Completion Date:** *04/07/2026*

***Implemented (█ - 05/18/2026)***

## 102e - Privacy - Doors/Partitions

**14. Requirements**

2600.
102.e. Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

**Description of Violation**

*On 3/2/2026 the following were observed:*

- *A lock was not present on the middle stall door in the shared bathroom on 5226 2nd floor, which does not afford privacy while in use.*
- *Gaps were observed on the stall doors in the shared bathroom on 5226 3rd floor, which does not afford privacy while in use.*
- *The stall doors in the shared bathroom on 5224 2nd floor did not have a lock, which does not afford privacy while in use.*

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

*The initial doors received were incorrect in size and did not provide locks and privacy. The facility had already ordered replacement bathroom stall doors prior to inspection and was waiting for delivery.*
*Temporary measures were implemented to ensure privacy, including:*
*staff monitoring bathroom use as needed*
*limiting use of affected stalls when appropriate*
*The contractor was immediately notified to address the issue.*

*The administrator has re ordered properly sized bathroom stall doors.*
*The correct doors are currently on order and pending delivery.*
*Upon arrival, all bathroom doors will be:*
*properly installed*
*equipped with functional locks*
*adjusted to eliminate any gaps to ensure full privacy*
*a complete inspection of all bathrooms has been conducted to identify and address any additional issues*

## 102e - Privacy - Doors/Partitions (continued)

***Monitoring***:
*Periodically, the administrator will conduct a walk-thru of all bathrooms to ensure privacy is maintained. Any identified privacy concerns will be immediately addressed or within 24-72 hours, depending on severity.*

**Licensee's Proposed Overall Completion Date:** *04/07/2026*

***Implemented (█ - 05/18/2026)***

## 102h - Toilet Paper

**15. Requirements**

2600.
102.h. Toilet paper shall be provided for every toilet.

**Description of Violation**

*On 3/2/2026, at approximately 9:35 am, there was no toilet paper for the toilet in the shared bathroom on 5526-3rd floor.*

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

*On March 2, 2026, immediately following the observation:*
*Toilet paper was restocked in the shared bathroom as the staff was on her way to clean said bathroom and restock toilet paper.*
*Staff on duty were reminded of the importance of maintaining adequate bathroom supplies at all times.*
***To Prevent Recurrence:***
*Staff will continue to check all shared bathrooms throughout the day to ensure:*
*toilet paper is available*
*hand soap is available*
*The facility's housekeeping policy has been reinforced to require that toilet paper and hand soap are available at all times in all bathrooms.*

***Monitoring***:
*Staff will provide a verbal report daily to the manager after completion of restocking bathrooms with supplies.*
*The administrator will conduct periodic walk-thru to verify that all bathrooms remain properly stocked.*
*Any missing supplies will be replaced immediately (same day).*

**Licensee's Proposed Overall Completion Date:** *04/07/2026*

***Implemented (█ - 05/18/2026)***

## 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 3/2/2026, at approximately 11:04 am, the temperature in the bread freezer was 14 degrees Fahrenheit and at 3:30 pm it was 10 degrees Fahrenheit.*

## *103f Refrigerator/Freezer Temps (continued)*

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

*During the inspection the temperature control was adjusted to maintain 0 degrees F or below, in accordance with safe food storage guidelines.*
*The freezer was re checked after adjustment, and the temperature was confirmed to be within the appropriate range.*
*All food items in the freezer were inspected to ensure food safety was not compromised.*

*A refrigerator/freezer temperature log has been implemented requiring staff to:*
*Check and document temperatures the first week of every month*
*Record any corrective actions taken*
*Any temperature reading above 0 degrees F will be addressed immediately, with rechecking and documentation of corrective action.*
*The freezer units will be monitored for proper function and, if needed, a maintenance professional will be contacted to inspect and calibrate the unit.*

*Staff will document freezer temperatures monthly*
*Administrator will review the log to ensure compliance and identify trends*

**Licensee's Proposed Overall Completion Date:** *04/08/2026*

***Implemented (█ - 05/18/2026)***

## 103i - Outdated Food

**17. Requirements**

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

**Description of Violation**

*There were three bags of unlabeled, undated chicken patties in the standup basement freezer.*

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

*Immediately following the inspection the unlabeled and undated chicken patties were discarded to ensure resident safety.*
*The entire freezer was inspected, and all food items were verified to be properly labeled, dated, and safe for consumption.*

*The facility has implemented a policy requiring that all food items placed in refrigerators and freezers must be labeled and dated upon storage.*
*A food storage has been implement4ed to ensure staff consistently follow proper labeling procedures.*
*The facility will follow the FIFO method to ensure older food items ae used first and prevent food from becoming outdated.*

*Staff will conduct weekly visual checks of all food storage areas to ensure compliance with labeling and dating requirements.*
*Any unlabeled or undated items identified will be discarded immediately and documented.*

## *103i - Outdated Food (continued)*

*The administrator will conduct periodic reviews of food storage and logs.*

**Licensee's Proposed Overall Completion Date:** *04/08/2026*

***Implemented (█ - 05/18/2026)***

## 132d - Evacuation

**18. Requirements**

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

**Description of Violation**

*During the fire drill on 5/10/2025 at 12:45 am, the evacuation time was 2 minutes 49 seconds, exceeding an evacuation time of 2 minutes 30 seconds. The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert.*

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

*On March 11, 2026, the facility conducted a review of the fire drill procedures and identified factors contributing to the delayed evacuation time.*

*Staff were immediately re-instructed on proper evacuation procedures including:*

*Prompt response to alarms*

*Assigned evacuation roles*

*Ensuring clear exit pathways*

*A follow-up fire drill was conducted to improve response time and ensure compliance.*

*The administrator has met with all residents to review fire drill procedures to ensure:*

*Residents understand the importance of evacuating immediately when the alarm rings.*

*All exit routes, hallways, and stairways will be reviewed to ensure they are clear of obstructions and allow for rapid evacuation.*

***Monitoring:***

*A fire drill log will be maintained documenting:*

*Date and time of drill*

*Evacuation time*

*Staff participation*

*Corrective actions*

*Each drill will be timed and and reviewed to ensure evacuation occurs within the established maximum safe evacuation time.*

*A weekly drill will be held and documented for the next 30 days to ensure ongoing compliance.*

*The administrator will review all fire drill documentation monthly to ensure compliance and identify any areas for improvement.*

**Licensee's Proposed Overall Completion Date:** *04/30/2026*

***Implemented (█ - 05/18/2026)***

## 132e - Fire Drill Sleeping Hours

**19. Requirements**

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

**Description of Violation**

*The last fire drill conducted during sleeping hours was on 5/10/2025 at 12:45 am.*

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

*On March 20, 2026, the facility conducted fire drill during sleeping hours to ensure immediate compliance.*
*Staff conducted the drill and was evaluated on:*
*response to alarm activation*
*execution of evacuation procedues*

*The facility has implemented a monthly fire drill schedule, ensuring drills are conducted at various times of day and evening.*
*At lease one fire drill will be conducted during sleeping hours within each required timeframe to maintain compliance.*
*The fire drill log will be used to document:*
*date and time of each drill*
*evacuation time, exit routes and performance*

*The administrator will indicate on the log when sleeping-hours drills are scheduled to ensure the drill occurs every six months.*

***Monitoring:***
*The administrator will review all fire drill documentation monthly to ensure:*
*drills are conducted at various times day, evening*
*sleeping-hour drills are completed within the required timeframes.*
*Fire drill records will be reviewed quarterly to verify ongoing compliance with 2600.132(e).*
*If a required sleeping-hours drill is missed it will be conducted immediately and documented.*

**Licensee's Proposed Overall Completion Date:** *04/08/2026*

***Implemented ( - 05/18/2026)***

## 141b1 - Annual Medical Evaluation

**20. Requirements**

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

**Description of Violation**

*Resident #1's most recent medical evaluation dated [redacted] was incomplete. The form does not include that the resident's needs can be met safely at the home.*

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

*On March 30, 2026, the facility contacted the resident's PCP to obtain a completed medical evaluation form*
*The PCP was requested to specifically address and document that the resident's needs can be safely met at the home.*

## 141b1 - Annual Medical Evaluation (continued)

*Upon receipt, the medical evaluation was reviewed for accuracy and completeness and placed in the resident record.*

*The administrator will conduct a quarterly review of resident medical evaluations to ensure:*
*the physician has documented that the residents' needs can be safely met at the home*
*medical evaluations are completed annually on time.*

*The facility will provide physicians with clear instructions on required forms to ensure all fields are completed properly.*

***Monitoring**:*
*All medical evaluations will be reviewed by the administrator prior to placement in the resident file*
*Administrator will periodically audit medical evaluations to ensure completeness.*
*Any incomplete medical evaluations identified will be returned to the physician immediately for completion.*

**Licensee's Proposed Overall Completion Date:** *04/08/2026*

***Implemented (█ - 05/18/2026)***

## 144d - Smoking Outside

**21. Requirements**

2600.
144.d. Smoking outside of the smoking room is prohibited.

**Description of Violation**

*On 3/2/2025, at approximately 11:00am, cigarette butts were observed outside the walkway to the smoking area and on the basement windowsill behind the washing machine outside the designated smoking area. The home's designated smoking area is on the right side of the building.*

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

*Immediately following the inspection:*
*all cigarette butts were removed and properly disposed of from the walkway and basement windowsill area.*
*the area was cleaned and inspected to ensure it was free of smoking debris*
*residents were immediately reminded that smoking is only permitted in the designated smoking area*

*Residents who smoke were re-educated on:*
*the location of the designated smoking area*
*the importance of smoking only in approved areas*
*proper disposal of cigarette butts*

*"No Smoking" signs will be posted in non-designated areas, including*
*walkways*
*basement areas*
*signage will clearly direct residents to the approved smoking area*

## *144d - Smoking Outside (continued)*

*The designated smoking area will be equipped with;*

*proper receptacles*

*regular cleaning to maintain sanitation*

*Staff will monitor outdoor areas daily to ensure compliance with smoking regulations.*

*The administrator will conduct monthly inspections of property to ensure no cigarette debris is present outside designated areaa.*

*Any cigarette debris found outside the designated area will be removed immediately, and residents will be re-educated as needed.*

**Licensee's Proposed Overall Completion Date:** *04/08/2026*

***Implemented (█ - 05/18/2026)***

## 183b - Meds and Syringes Locked

### 22. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

### Description of Violation

*On 3/2/2026, padlocks were present on the medication room cabinets. However, the cabinets were unlocked, unattended, and accessible in the medication room, which is also used as an emergency exit.*

### Plan of Correction ***Accept (█ - 04/14/2026)***

*Immediately following the inspection:*

*all medication cabinets were secured and locked immediately*

*access to the medication cabinets was restricted to authorized staff only*

*staff on duty were immediately re-educated on the requirement that the medications must remain locked at all times when not in use.*

*The facility's medication management policy has been reinforced to require that:*

*all medications are locked at all times when not in use*

*cabinets must never be left unattended while unlocked*

*All staff will be trained no later than April 30, 2026 on:*

*medication security requirements under 2600.183(b)*

*proper procedures for accessing and securing medications*

*responsibilities when using shared or multi-purpose spaces (e.g. medication room, emergency exit)*

*A reminder sign will be posted inside the medication room stating:*

*"All medication cabinets must remain locked when not in use"*

***Monitoring:***

*The manager thru out the day will spot check to ensure cabinets are properly locked when not in use.*

*The administrator will conduct weekly inspections of the medication storage area*

*Any instance of unlocked medication storage will be corrected immediately , documented and followed by staff re-education*

**Licensee's Proposed Overall Completion Date:** *04/08/2026*

***Implemented (█ - 05/18/2026)***

## 187b - Date/Time of Medication Admin.

**23. Requirements**

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

**Description of Violation**

*Resident #2 is prescribed Myrbetriq 50 mg Tab take one tablet by mouth one time a day at 8:00 am. Resident #2's 2/5/2026 to 3/6/2026 medication administration record does not include the initials of the staff person who administered the medication on 2/17/2026, 2/18/2026, 2/19/2026, 2/20/2026, 2/21/2026, 2/22/2026, 2/23/2026, 2/24/2026, 2/25/2026, 2/26/2026, 2/27/2026, 2/28/2026, 3/1/2026, 3/2/2026, 3/3/2026. The medication was no longer in the package.*

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

*Immediately following the inspection:*
*The MAR was reviewed and corrected to the extent possible, with notation made regarding missing documentation*
*The pharmacy was contacted to verify medication continuation and ensure proper supply*
*A new medication supply was obtained and placed in properly labeled packaging.*
*Staff involved were re-educated on proper MAR documentation requirements, including the requirement to initial immediately after administration.*
*The facility has reinforced its policy requiring that:*
*staff must initial the MAR immediately after administering medication*
*each entry must include date, time and staff initials*
*all medications will remain in original pharmacy packaging or properly labeled containers at all times to ensure accurate tracking and verification.*
*The lead med-tech will conduct weekly reviews of MAR's to ensure completeness and accuracy*

***Monitoring**:*
*The manager will thru-out the month review medications and medication records to identify and correct any discrepancies. Any missing initials or documentation errors will be addressed immediately, with staff re-education and documentation of corrective action.*

**Licensee's Proposed Overall Completion Date:** *04/08/2026*

***Implemented ( - 05/18/2026)***

## 227d - Support Plan Medical/Dental

**24. Requirements**

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

**Description of Violation**

*The assessment for resident #3, dated , indicates the resident does not have a need for managing finances. However, the home provides financial assistances.*

## *227d Support Plan Medical/Dental (continued)*

*The assessment for resident #6, dated [redacted], indicates the resident does not have a need for managing [redacted] finances. However, the home provides financial assistances.*

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

*On March 9, 2026, the administrator:*

*reviewed and corrected the assessments for resident #3 and resident #6 to accurately reflect their need for financial management assistance.*

*verified that services being provided are now consistent with the documented assessments.*

*The manager will quarterly spot check assessments to identify and "clerical errors" such as the one that occurred for residents #3 and #6.*
*Any errors will be brought to the attention of the administrator for immediate correction.*

***Monitoring:***
*Periodically, the administrator will audit assessments to ensure they accurately reflect services provided. Any discrepancies identified will be corrected immediately, with documentation of the correction and staff re education if needed.*

**Licensee's Proposed Overall Completion Date:** *04/08/2026*

***Implemented ( - 05/18/2026)***

## 251b - Record Entries Legible

**25. Requirements**

2600.
251.b. The entries in a resident’s record must be permanent, legible, dated and signed by the staff person making the entry.

**Description of Violation**

*The fire drill conducted on 6/11/2025 has the number of residents in the home and the number of residents that evacuated were written over.*

*The fire drills conducted on 5/10/2025, 8/12/2025, and 10/9/2025 has the number of staff participating written over.*

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

***Immediate corrective action taken:***
*On March 17, 2026, the administrator:*

*reviewed all identified fire drill records and recreated clear, legible documentation*

*ensured corrected entries were clearly written, dated and initialed, with appropriate notations*

*staff responsible for documentation were re educated on proper recordkeeping standards*

***To Prevent Recurrence**:*

*the standardized fire drill log form will be used to reduce errors and ensure consistent documentation*

*Staff will be trained on:*

*proper documentation practices*

## *251b - Record Entries Legible (continued)*

*acceptable correction procedure (draw a single line thru the error, initial and date)*
*importance of maintaining legible records for compliance*
*The manager will review all fire drill documentation immediately after completion to ensure accuracy and legibility.*

***Monitoring**:*
*All fire drill documentation will be reviewed the same day by the manager or administrator for completeness and clarity*
*The administrator will quarterly review the logs to ensure compliance.*
*Any illegible or incorrect entry will be corrected promptly using proper procedures and staff will be re-educated as needed. Findings will be reviewed and placed on the next staff meeting agenda for continuous improvement purposes.*

**Licensee's Proposed Overall Completion Date:** *04/07/2026*

***Implemented ( - 05/18/2026)***