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

June 18, 2026

[redacted], PRESIDENT
SENECA MANOR, LLC
[redacted]

RE: SENECA MANOR
5340 SALTSBURG ROAD
VERONA, PA, 15147
LICENSE/COC#: 45549

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/02/2026, 03/04/2026, 03/13/2026 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: *SENECA MANOR* **License #**: *45549* **License Expiration**: *04/01/2027*

Address: *5340 SALTSBURG ROAD, VERONA, PA 15147*

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

Administrator

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

Legal Entity

Name: *SENECA MANOR, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I 2* **Date**: *04/14/2010* **Issued By**: *Municipality of Penn Hills*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *119* **Waking Staff**: *89*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *03/13/2026*

Inspection Dates and Department Representative

03/02/2026 On Site: [redacted]
03/04/2026 On Site: [redacted]
03/13/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *76*

Special Care Unit

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

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *76*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *43* **Have Physical Disability**: *2*

Inspections / Reviews

03/02/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *05/15/2026*

Inspections / Reviews *(continued)*

05/22/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/01/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/01/2026*

05/27/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/01/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/03/2026*

06/18/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/01/2026*

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

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

Description of Violation

On 3/2/2026, a copy of Pennsylvania Code, Title 55. Public Welfare, Department of Public Welfare Chapter 2800 Assisted Living Residences, was not posted in a conspicuous and public place in the assisted living residence.

On 3/2/2026, a copy of the license inspection summary dated 2/11/2025 et al. was not posted in a conspicuous and public place in the assisted living residence.

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

On 3/2/2026, the residence immediately posted a current copy of Pennsylvania Code, Title 55, Chapter 2800 Assisted Living Residences, and the current license inspection summary dated 2/11/2025 in a conspicuous and public location within the assisted living residence.
All residents, families, visitors, staff, and other members of the public had the potential to be affected by not having access to the required posted information.
The Administrator/designee will maintain a regulatory posting binder/checklist to ensure the current license, most recent license inspection summary, and Chapter 2800 regulations are posted and remain accessible in a conspicuous public location. Leadership staff will be educated 4/6/26 on the posting requirement.
The Administrator/designee will audit the required postings weekly for four weeks, then monthly for 1 month to ensure continued compliance. Findings will be reviewed and addressed promptly, starting on 3/9/2026.
Corrective action was completed on 3/2/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

16c Incident reporting

2. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], police were called to escort staff person A out of the building; however, this incident was not reported to the Department.

On 1/8/2026, [redacted] the residence's former administrator, went into the medication storage areas on all three floors of the residence and removed and destroyed numerous narcotic medications belonging to current residents that were not damaged, discontinued, or expired, to include the following:

**1 30ml bottle of Morphine Sulphate 100mg/5ml solution belonging to resident #2*
**24 Lorazepam 1mg tablets belonging to resident #2*
**15 Oxycodone/APAP tab 5-325mg tablets belonging resident #13*

16c Incident reporting (continued)

This incident was not reported to the Department.

Plan of Correction ***Directed (- 05/27/2026)***

The residence conducted an immediate review of the incidents cited. The events involving police escort of Staff Person A on 3/5/2026 and the medication destruction incident involving former Administrator on 1/8/2026 were reviewed with current leadership to ensure understanding of mandatory reporting requirements. Incidents will be submitted to the department for both incidents referenced in violation report.

Directed Within 24 hours of receipt of the plan of correction, both incidents will be reported to the Department via email to
5.27.2026

Education was provided to the Administrator and leadership team regarding reportable incidents and required Department notification timeframes under Chapter 2800 regulations.
All residents residing in the community at the time of the incidents had the potential to be affected by the failure to timely report reportable events to the Department. A review of incident reporting practices was completed to determine if additional reportable events had not been appropriately communicated. No additional unreported incidents were identified during the review.
The residence implemented on 5/4/26 a revised incident reporting process that includes:
• Immediate review of all significant incidents by the Administrator/designee.
• A reportable event checklist identifying incidents requiring Department notification.
• Education and retraining of leadership staff regarding mandatory reporting requirements, timelines, and documentation expectations under Chapter 2800.
• A requirement that all police involvement, allegations involving controlled substances, diversion concerns, abuse allegations, or significant employee misconduct be escalated immediately to the Executive Director/designee for determination of reporting obligations.
The Administrator/designee will audit starting 5/4/26 all incident reports and significant event documentation weekly for four weeks, then monthly for three months, to ensure reportable incidents are communicated to the Department within required timeframes. Any concerns identified during audits will be addressed immediately through additional education and corrective action as indicated.
Education completed by 5/19/2026. Ongoing monitoring will continue as outlined above.

Proposed Overall Completion Date: 05/29/2026

Directed Completion Date: *05/29/2026*

Implemented (- 06/17/2026)

42x Safeguard money/property

3. Requirements

2800.
42.x. A resident has the right to a system to safeguard a resident's money and property.

Description of Violation

On 1/8/2026, , the residence's former administrator, went into the medication storage areas on all three

42x Safeguard money/property (continued)

floors of the residence and removed and destroyed numerous narcotic medications belonging to current residents that were not damaged, discontinued, or expired, to include the following:

**1 30ml bottle of Morphine Sulphate 100mg/5ml solution belonging to resident #2*
**24 Lorazepam 1mg tablets belonging to resident #2*
**15 Oxycodone/APAP tab 5-325mg tablets belonging resident #13*

Plan of Correction ***Accept (- 05/22/2026)***

The residence reviewed the medication destruction incident involving former Administrator on 1/8/2026. The individual identified in the citation is no longer employed by the residence.
All residents with medications stored within the medication storage areas had the potential to be affected. The residence completed an audit of medication storage practices, narcotic counts, and medication destruction documentation to ensure no additional unauthorized removal or destruction of resident medications will occur.
The residence revised and reinforced medication security and controlled substance handling procedures, including:
• Re-educating leadership and medication management staff regarding resident rights and safeguarding resident property, including medications.
• Reinforcing policies related to medication destruction, including physician orders, proper documentation, witness requirements, and pharmacy consultation when applicable.
• Implementing additional oversight of narcotic count reconciliation and medication destruction practices by nursing leadership/designee.
• Requiring immediate escalation to corporate leadership of any suspected diversion, unauthorized medication handling, or medication discrepancies.
The Administrator/designee will conduct weekly audits of narcotic counts, medication destruction records, and medication storage security for two weeks, then one time weekly for two weeks, monthly thereafter to ensure ongoing compliance. Any discrepancies identified will be investigated immediately and addressed through corrective action and additional staff education as indicated.
Corrective action, staff education, and implementation of revised oversight measures completed by 5/19/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 06/17/2026)

53a Admin. qualifications

4. Requirements

2800.
53.a. The administrator shall have one of the following qualifications:

1. A license as an RN from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.
2. An associate's degree or 60 credit hours from an accredited college or university in a human services field and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.
3. An associate's degree or 60 credit hours from an accredited college or university in a field that is not related to human services and 2 years, in the prior 10 years, of direct care or administrative experience in a health care or human services field.
4. A license as an LPN from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.

53a Admin. qualifications *(continued)*

5. A license as a nursing home administrator from the Department of State and 1 year, in the prior 10 years, of direct care or administrative experience in a health care or human services field.
6. With the exception of administrators qualified under § 2600.53(a)(5) (relating to qualifications and responsibilities of administrators), experience as a personal care home administrator, if the following requirements are met:
   i. Employed as a personal care home administrator for 2 years prior to January 18, 2011.
   ii. Completed the administrator training requirements and pass the Department-approved competency-based training test in § 2800.64 (relating to administrator training and orientation) by January 18, 2012.

Description of Violation

[redacted] *the residence's former administrator, was hired on* [redacted] *However,* [redacted] *RN license was automatically suspended for one (1) year and indefinitely suspended for a period of no less than three (3) years to run concurrently with such suspensions to be immediately stayed in favor of no less than three (3) years of probation effective* [redacted] *by the Pennsylvania State Board of Nursing. There was no other record of meeting a qualification to perform as an administrator in* [redacted] *records.*

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

The residence reviewed the qualifications of the former administrator identified in the citation on . [redacted] *is no longer employed by the residence. On* [redacted]*, the residence hired a new Administrator who possesses a current Pennsylvania Nursing Home Administrator license and meets the qualifications outlined under §2800.53(a)(5).*

All residents residing in the community during the period in question had the potential to be affected by the residence not having a qualified administrator in place. The residence reviewed administrative personnel records and credential verification processes to ensure all current leadership staff meet applicable regulatory requirements.

The residence revised on 5/2/26 its hiring and credential verification procedures to ensure:

- *All administrator credentials, licenses, and qualifications are verified prior to hire.*
- *Verification of licensure status will include review through the applicable Pennsylvania licensing board website.*
- *Documentation of qualification verification will be maintained in the employee personnel file.*
- *Corporate leadership and Human Resources will review and approve administrator qualifications prior to placement in the role.*

The Administrator/designee and Human Resources will audit leadership personnel files quarterly starting on 5/2/26 for one year to ensure required credentials, licenses, and qualification documentation are present and current. Any discrepancies identified will be addressed immediately.

Corrective action was completed on 2/22/2026 with the hiring of a qualified Administrator. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

57c 2 hrs/day/immob. resident

5. Requirements

2800.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

57c 2 hrs/day/immob. resident *(continued)*

Description of Violation

On 2/22/2026, there were 74 residents in the residence, including 46 residents with mobility needs, requiring a total minimum of 120 hours of direct care service. On this date, only 81.55 hours of direct care staffing was provided.

On 3/2/2026, there were 73 residents in the residence, including 46 residents with mobility needs, requiring a total minimum of 119 hours of direct care service. On this date, only 94.48 hours of direct care staffing was provided.

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

The residence reviewed staffing levels and resident care needs related to the dates cited. A new staffing plan was developed and implemented to ensure sufficient direct care staffing hours are scheduled to meet the required minimum hours for residents with mobility needs. Staffing schedules were adjusted to increase direct care coverage and better align staffing patterns with resident acuity and service needs.
All residents requiring mobility assistance had the potential to be affected by insufficient direct care staffing hours. The residence conducted a review of resident assessments, mobility needs, staffing schedules, and staffing ratios to ensure current staffing levels appropriately support resident care requirements.
The residence implemented the following systemic changes:
• A revised staffing plan based on resident acuity, mobility needs, and required care hours.
• Daily monitoring of resident census and mobility classifications to ensure required staffing hours are met or exceeded.
• Increased oversight of scheduling practices by leadership to ensure staffing compliance.
• Ongoing recruitment and retention efforts to maintain adequate staffing levels.
• Education provided to leadership staff regarding regulatory staffing requirements under Chapter 2800.
The Administrator/designee will review staffing schedules, actual worked hours, and resident mobility calculations with any additional admissions on 5/2/26, to ensure compliance with required direct care staffing hours. Any identified variances will be addressed immediately through staffing adjustments and corrective action as necessary. The revised staffing plan was implemented by 5/2/2026. Ongoing monitoring will continue.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

57d Waking staff hours

6. Requirements

2800.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 2/22/2026, there were 74 residents in the residence, including 46 residents with mobility needs, requiring a total minimum of 90 hours of direct care service during waking hours or 75 %. However, on this date, only 50.58 hours of direct care staffing was provided during waking hours.

On 2/27/2026, there were 72 residents in the residence, including 46 residents with mobility needs, requiring a total minimum of 88.50 hours of direct care service during waking hours or 75 %. However, on this date, only 72 hours of direct care staffing was provided during waking hours.

57d Waking staff hours (continued)

On 3/2/2026, there were 73 residents in the residence, including 46 residents with mobility needs, requiring a total minimum of 89.25 hours of direct care service during waking hours or 75 %. However, on this date, only 69.98 hours of direct care staffing was provided during waking hours.

Plan of Correction ***Accept (- 05/27/2026)***

The residence evaluated staffing coverage during waking hours related to the dates cited. Scheduling adjustments were made to increase direct care staffing presence during daytime and evening hours to ensure resident care needs are adequately supported during residents' waking hours. The newly developed staffing plan was revised to specifically account for the required distribution of care hours during waking shifts.
All residents requiring personal care services during waking hours had the potential to be affected by insufficient staffing coverage during those time periods. The residence reviewed staffing assignments, resident acuity levels, and care hour allocations to ensure staffing resources appropriately align with resident needs throughout waking hours.
The residence implemented the following systemic changes:
• Revision of shift staffing patterns to ensure compliance with waking-hour staffing requirements.
• Daily review of staffing distribution between waking and non-waking hours based on census and resident acuity.
• Increased oversight of scheduling practices to ensure adequate staffing coverage during peak resident activity periods.
• Education provided to leadership staff regarding regulatory staffing requirements under Chapter 2800.
The Administrator/designee will review staffing schedules, actual worked hours, and resident mobility calculations with any additional admissions 5/2/26, to ensure compliance with required direct care staffing hours. Any identified variances will be addressed immediately through staffing adjustments and corrective action as necessary.
The revised staffing plan was implemented by 5/2/2026. Ongoing monitoring will continue.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 06/17/2026)

60a Staffing/support plan needs

7. Requirements

2800.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

On 3/2/2026, there were 73 residents present in the 3-story residence, including 46 residents with mobility needs. Of the 46 residents with mobility needs, 4 of the residents require the physical assistance of 2 staff persons to transfer in/out of bed/chair. According to the most recent documentation from a fire safety expert, dated 4/23/2025, the maximum evacuation time to the home's numerous internal fire-safe areas is 10 minutes. On 3/2/2026, there were 3 staff members working in the building from 11:07pm- 11:59pm, which is not adequate to evacuate all residents in an emergency.

Plan of Correction ***Accept (- 05/27/2026)***

The residence reviewed overnight staffing levels, resident acuity, transfer needs, and emergency evacuation requirements related to the date cited. Staffing assignments and overnight coverage were adjusted through

60a Staffing/support plan needs (continued)

implementation of the revised staffing plan to ensure sufficient staff are available to meet resident care needs and emergency response requirements.
All residents residing within the residence had the potential to be affected by insufficient overnight staffing coverage.
The residence reviewed resident assessments, mobility assistance requirements, evacuation needs, and staffing schedules to ensure staffing levels appropriately reflect resident acuity and safety needs
The residence implemented the following systemic changes:
• Revision of shift staffing patterns to ensure compliance with waking-hour staffing requirements.
• Daily review of staffing distribution between waking and non-waking hours based on census and resident acuity.
• Increased oversight of scheduling practices to ensure adequate staffing coverage during peak resident activity periods.
• Education provided to leadership staff regarding regulatory staffing requirements under Chapter 2800.
The Administrator/designee will review staffing schedules, actual worked hours, and resident mobility calculations with any additional admissions, to ensure compliance with required direct care staffing hours. Any identified variances will be addressed immediately through staffing adjustments and corrective action as necessary.
The revised staffing plan was implemented by 5/2/2026. Ongoing monitoring will continue.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

63a First Aid/CPR 1:35

8. Requirements

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

On 2/22/2026, there were 74 residents in the residence, requiring a total of 3 staff members trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents. However, there were 2 staff persons present for the 6:30 am to 3:00 pm shift and one staff person present for the 2:30 pm to 10:30 pm shift who was trained in first aid and certified in obstructive airway techniques and CPR.

Plan of Correction ***Accept ([redacted] - 05/22/2026)***

The residence reviewed staff schedules and CPR/first aid certification records related to the date cited. Staffing assignments were adjusted to ensure the required number of staff trained in first aid and certified in CPR and obstructed airway techniques are scheduled and present on all shifts based on census requirements.
All residents residing within the residence had the potential to be affected by insufficient numbers of certified staff present during the identified shifts. The residence conducted an audit of current employee certification records and staffing schedules to ensure compliance with required certification coverage.
The residence implemented the following systemic changes:
• Revision of staffing and scheduling practices to ensure required CPR/first aid certified staff coverage on all shifts.
• Development of a certification tracking system to monitor employee certification status and expiration dates.
• Scheduling additional CPR, first aid, and obstructed airway training courses for staff as needed to maintain compliance.
• Increased oversight by leadership to verify certified staffing coverage prior to finalizing schedules.
• Education provided to leadership staff regarding regulatory staffing and certification requirements under Chapter 2800.

63a First Aid/CPR 1:35 (continued)

The Administrator/designee will review staffing schedules, actual worked hours, and resident mobility calculations daily for four weeks, to ensure compliance with required direct care staffing hours. Any identified variances will be addressed immediately through staffing adjustments and corrective action as necessary.
Additionally, CPR/first aid certification records will be audited to ensure sufficient certified staff coverage is maintained at all times.
Scheduling adjustments and certification reviews were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 06/17/2026)

64a Initial admin training

9. Requirements

2800.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
1. An orientation program approved and administered by the Department.

Description of Violation

[redacted] *the residence's former administrator, was hired on* [redacted] *and did not have documentation of completion of an orientation program approved and administered by the Department .*

Plan of Correction ***Accept (- 05/27/2026)***

The residence reviewed the qualifications and training documentation of the former administrator identified in the citation. The individual is no longer employed by the residence. The current Administrator meets the qualifications required under Chapter 2800, including completion of the required Department approved orientation program, as evidenced by documentation provided to the Department.
All residents residing within the residence during the period in question had the potential to be affected by the lack of documented administrator orientation completion. The residence reviewed current leadership personnel files to ensure required training and orientation documentation is present and maintained.
The residence revised its hiring and onboarding procedures to ensure:
• Verification of successful completion of all required Department approved administrator orientation and training programs prior to placement in the administrator role.
• Maintenance of all training and orientation documentation within personnel files.
• Review and approval of administrator qualifications and required documentation by Human Resources and corporate leadership prior to hire.
• Ongoing oversight of leadership credential and training compliance.
The Administrator/designee and Human Resources will audit leadership personnel files quarterly starting 5/2/26 for one year to ensure all required orientation, training, and qualification documentation is complete and maintained. Any discrepancies identified will be addressed immediately.
Corrective action was completed on 3/2/2026 with the hiring of a qualified Administrator meeting Chapter 2800 requirements. Revised onboarding and verification procedures were completed by 3/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 06/17/2026)

65j Annual training content

10. Requirements

2800.
65.j. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff person F, date of hire [redacted], did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert in training year January 1, 2025 to December 31, 2025.

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

Staff Person F received the required fire safety training completed by an appropriately qualified individual on her hire date [redacted] which was located after citation issued. Training documentation was updated and placed in the employee personnel file. The residence reviewed current fire safety training records to ensure staff have completed required annual training.
All residents residing within the residence had the potential to be affected by staff not having current fire safety training. The residence conducted an audit of employee training records to identify any additional staff members who may have missing or expired annual fire safety training requirements.
The residence implemented the following systemic changes:
• Development of a training tracking system to monitor annual training requirements and expiration dates.
• Assignment of leadership responsibility for ongoing review of employee training compliance.
• Scheduling of annual fire safety training sessions completed by a qualified fire safety expert or trained designee.
• Education provided to leadership staff regarding regulatory training requirements under Chapter 2800.
The Administrator/designee will audit employee training records starting 5/2/26, quarterly thereafter to ensure required annual fire safety training is completed and documented timely. Any identified deficiencies will be addressed immediately through corrective action and staff education.
Corrective action and staff training review were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

81b Resident equip – good repair

11. Requirements

2800.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 3/2/2026, at approximately 11:25 am, resident #3 had a bedside mobility device that slides under the mattress and was not securely attached to the structure of the bed.

On 3/2/2026 at approximately 12:03 pm, resident #10 had 2 bedside mobility devices that slide under the mattress and were not securely attached to the structure of the bed.

81b Resident equip – good repair *(continued)*

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

The bedside mobility devices identified for Residents #3 and #10 were immediately secured in accordance with manufacturer recommendations to eliminate potential hazards. The residence assessed the devices to ensure they were stable, properly installed, and safe for resident use.

All residents utilizing bedside mobility devices or other assistive apparatus had the potential to be affected. The residence completed a full audit of resident mobility and assistive devices throughout the community to ensure equipment was properly installed, secure, and free from hazards.

The residence implemented the following systemic changes:

• Education provided to staff regarding proper installation, inspection, and monitoring of bedside mobility devices and assistive equipment.

• Implementation of routine environmental and equipment safety rounds to identify potential hazards.

• Increased oversight by leadership to ensure resident assistive devices remain safe and properly secured.

The Administrator/designee will conduct weekly audits beginning 5/4/26 of resident assistive devices and environmental safety rounds for three weeks, to ensure equipment remains properly secured and hazard free. Any identified concerns will be corrected immediately and addressed with additional staff education as necessary.

Corrective action and the full equipment audit were completed on 4/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

92 Windows/screens

12. Requirements

2800.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 3/2/2026, the lower portion of the window screen in the window in resident #7's living unit was torn/worn off, creating an approximately 18"W x 4" H area with no screen.

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

The damaged window screen in Resident #7's living unit was immediately repaired/replaced to ensure the window was securely screened and in good repair.

All residents residing within the residence had the potential to be affected by damaged or improperly maintained window screens. The residence conducted a full environmental audit of resident room windows and screens throughout the building to identify and correct any additional concerns.

The residence implemented the following systemic changes:

• Education provided to maintenance and leadership staff regarding environmental safety and preventive maintenance requirements under Chapter 2800.

• Addition of window and screen inspections to routine environmental rounds and preventive maintenance inspections.

The Administrator/designee or maintenance director will conduct weekly environmental rounds beginning 5/4/26 for four weeks, to ensure windows and screens remain in good repair and free from hazards. Any identified concerns will be corrected immediately.

92 Windows/screens (continued)

Corrective action and the environmental audit were completed on 4/30/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

95 Furniture & Equipment

13. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 3/2/2026, the handheld shower head in resident #4's private bathroom had a broken handle with a piece of it missing, creating a sharp edge.

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

The handheld shower head in Resident #4's bathroom was immediately repaired/replaced to eliminate the sharp edge and ensure the equipment was safe for resident use.
All residents residing within the residence had the potential to be affected by damaged furniture or equipment. The residence completed an environmental safety audit of resident bathrooms and common area equipment to identify and correct any additional hazards.
The residence implemented the following systemic changes:
• Education provided to maintenance, housekeeping, and leadership staff regarding identification and reporting of environmental hazards.
• Reinforcement of procedures requiring prompt repair or replacement of damaged equipment identified by staff.
The Administrator/designee or maintenance director will conduct weekly environmental and equipment safety rounds for four weeks starting 5/2/26, to ensure furniture and equipment remain in good repair and hazard free. Any identified concerns will be corrected immediately.
Corrective action and the environmental audit were completed on 4/17/2026. Ongoing monitoring

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

103c Food protected

14. Requirements

2800.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 3/2/2026, at approximately 1:50pm, there were two uncovered metal baking sheets full of lemon bars and one metal baking sheet full of orange gelatin dessert stored on a portable shelving unit in the homes walk-in refrigerator.

Plan of Correction ***Accept ([redacted] - 05/22/2026)***

The uncovered food items identified in the walk-in refrigerator were immediately covered and properly stored to protect against contamination. Dietary staff were immediately educated on proper food storage and sanitation requirements.

103c Food protected (continued)

All residents receiving food service within the residence had the potential to be affected by improper food storage practices. The residence conducted a full inspection of food storage areas, refrigeration units, and food handling practices to ensure compliance with sanitation and food safety requirements.
The residence implemented the following systemic changes:
• Re-education of dietary staff regarding proper food storage, covering, labeling, and sanitation practices.
• Reinforcement of infection control and food safety procedures related to food protection and contamination prevention.
• Increased oversight by dietary leadership to ensure compliance with safe food handling and storage standards.
The Administrator/designee and Dietary Manager will conduct weekly kitchen sanitation and food storage audits for four weeks, to ensure food items are properly protected from contamination. Any identified concerns will be corrected immediately and addressed with additional staff education as necessary.
Corrective action and dietary staff education were completed on 3/17/2026. Ongoing monitoring processes were implemented by 3/17/2026 and will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented ([redacted] - 06/17/2026)

132b Safety inspection/fire drill

15. Requirements

2800.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The most recent fire safety inspection and fire drill conducted by a fire safety expert was completed on 4/23/2025; however, the residence did not have documentation of the fire safety inspection and fire drill conducted by a fire safety expert completed in 2024.

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

No residents were affected by the deficient practice. The residence confirmed that the most recent fire safety inspection and fire drill conducted by a fire safety expert was completed on 4/23/2025 as well as 4/21/26 and documentation is maintained onsite. The residence is unable to retroactively correct the absence of 2024 documentation, this was past non compliance and 2025 and 2026 are completed
All residents residing within the residence had the potential to be affected by incomplete documentation retention. The residence reviewed current fire safety documentation records to ensure all available and required documentation is present and properly maintained.
The residence implemented the following systemic changes:
• Development of a compliance tracking system for annual fire safety inspections, drills, and required documentation retention.
• Designation of leadership responsibility for maintaining and auditing required life safety documentation.
• Education provided to leadership staff regarding documentation retention requirements under Chapter 2800.
The Administrator/designee will audit fire safety documentation quarterly for one year to ensure required inspections, drills, and supporting documentation are completed and maintained appropriately. Any identified deficiencies will be corrected immediately.
Review of current documentation and implementation were completed on 4/23/25. Ongoing monitoring will continue as outlined above.

132b Safety inspection/fire drill (continued)

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 06/17/2026)

132c Fire drill records

16. Requirements

2800.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The residence's fire drill record does not include the number of residents evacuated during the fire drill conducted on 5/19/2025 at 9:30 AM.

Plan of Correction ***Accept (- 05/27/2026)***

No residents were affected by the deficient practice. Facility unable to correct number of residents evacuated in 2025. Unable to determine number of residents evacuated on this past noncompliance. The residence reviewed the fire drill documentation process and updated fire drill documentation forms to ensure all required elements are included and completed for future drills.
All residents residing within the residence had the potential to be affected by incomplete fire drill documentation. The residence reviewed current fire drill records to ensure all required documentation components are completed and maintained.
The residence implemented the following systemic changes:
• Revision of the fire drill documentation form/checklist to include all required regulatory elements under Chapter 2800.
• Education provided to leadership and staff responsible for conducting and documenting fire drills regarding required documentation standards.
• Increased oversight by leadership to ensure fire drill records are reviewed for completeness following each drill.
The Administrator/designee will audit fire drill documentation after each fire drill for one year to ensure all required information is accurately completed and maintained. Any identified deficiencies will be corrected immediately and addressed through additional education as necessary.
Updated documentation procedures and staff education were completed by 4/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 06/18/2026)

132g Fire drills – days/times

17. Requirements

2800.
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.

132g Fire drills – days/times *(continued)*

Description of Violation

The residence routinely schedules 4 staff during the 10:30 pm to 7:00 am shift. However, the residence has not conducted a fire drill in the past year with only 4 staff participating. One fire drill was conducted with 5 staff participating on 12/11/2025 at 2:45am.

Plan of Correction ***Accept (- 05/22/2026)***

No residents were affected by the deficient practice. The residence reviewed fire drill scheduling practices and conducted education with leadership regarding requirements for conducting drills under normal staffing conditions representative of actual staffing patterns.
All residents residing within the residence had the potential to be affected by fire drills not accurately reflecting typical overnight staffing conditions. The residence reviewed prior fire drill practices and current overnight staffing patterns to ensure future drills appropriately reflect routine staffing levels.
The residence implemented the following systemic changes:
• Revision of fire drill scheduling procedures to ensure drills are conducted under varying staffing conditions and representative of actual routine staffing levels.
• Development of a fire drill tracking log to monitor drill dates, times, staffing participation, and shift coverage.
• Education provided to leadership staff responsible for scheduling and conducting fire drills regarding regulatory requirements under Chapter 2800.
• Increased oversight by leadership to ensure future overnight drills are conducted with routine overnight staffing levels whenever possible.
The Administrator/designee will review all fire drill documentation after each drill for one year to ensure drills are conducted on varying shifts, days, and staffing conditions in compliance with Chapter 2800 requirements. Any identified concerns will be addressed immediately through corrective action and additional education as necessary.
Revised fire drill scheduling procedures and staff education were completed by 4/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 06/18/2026)

141a Medical evaluation

18. Requirements

2800.
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. The evaluation must include the following:
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

Description of Violation

Resident #8's initial medical evaluation, dated , indicates "see attached med list" for the resident's medication regimen; however, there is no medication list/regimen attached.

Repeat Violation- 2/11/2025, et al.

Plan of Correction ***Accept (- 05/27/2026)***

Resident #8's medical evaluation was reviewed and updated to ensure the resident's medication regimen was complete and properly attached to the evaluation form by CRNP. as required. The resident record was audited for

141a Medical evaluation (continued)

completeness and accuracy.
All residents admitted to the residence had the potential to be affected by incomplete medical evaluation documentation. The residence conducted an audit of resident medical evaluations to ensure required medication regimen documentation is present and complete within resident records.
The residence implemented the following systemic changes:
• Re-education of nursing and admissions staff regarding completion and review requirements for medical evaluations under Chapter 2800.
• Increased oversight by leadership to verify completeness of medical evaluations during the admission review process.
The Administrator/designee or nurse will audit all new admission medical evaluations weekly for four weeks starting 5/4/26, then monthly for three months, to ensure all required documentation, including medication regimens and attachments, are complete and maintained in the resident record. Any identified deficiencies will be corrected immediately.
Corrective action and record audit were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

141b1 Annual medical evaluation

19. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident #4's most recent medical evaluation was completed on [redacted]

Resident #5's most recent medical evaluation was completed on [redacted]

Repeat Violation- 2/11/2025, et al.

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

Resident #4 d/c from facility on [redacted] and Resident #5 was scheduled for updated medical evaluations to ensure compliance with annual evaluation requirements. Resident records were reviewed and updated accordingly upon receipt of completed evaluations. on 5/11/26 by MD.
All residents residing within the residence had the potential to be affected by overdue annual medical evaluations. The residence conducted an audit of resident medical evaluation dates to identify any additional residents requiring updated evaluations.
The residence implemented the following systemic changes:
• Development of a tracking system to monitor due dates for annual medical evaluations.
• Implementation of advance notification procedures to alert nursing and leadership staff of upcoming evaluation deadlines.
• Re-education of nursing and leadership staff regarding annual medical evaluation requirements under Chapter 2800.

141b1 Annual medical evaluation (continued)

• Increased oversight of resident record compliance through routine chart audits.
The Administrator/designee or nurse will audit resident medical evaluation dates weekly for four weeks, then monthly for three months, to ensure annual evaluations are completed timely and maintained in resident records. Any identified deficiencies will be addressed immediately.
Corrective action and resident record audits were completed by 5/15/2026. Staff education and implementation of the tracking process were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

183b Medications and syringes locked

20. Requirements

2800.
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 living unit.

Description of Violation

On 3/4/2026, at approximately 10:06 am, there was a loose white tablet on top of the medication cart in the 3rd floor medication room. Staff person G, the medication technician, identified the tablet as a Calcium Acetate 667mg.

According to resident #6's assessment, dated [redacted], the resident is unable to self administer medications. On 3/4/2026, at approximately 11:50 am, there were numerous unlocked and unattended medications in resident #6's resident living unit, to include PreviDent Dental Gel 1.1%, and a bottle of nystatin powder 100000 unit/gram.

Plan of Correction ***Directed ([redacted] - 05/27/2026)***

The loose medication identified on top of the medication cart was immediately removed and properly secured. Staff Person G received immediate re education regarding proper medication handling, storage, and medication cart security procedures. Resident #6's care plan was reviewed and updated to reflect the resident's ability to self administer medications as appropriate and deemed appropriate to self administer.

Directed: Resident #6 has an order from MD received on 4/24/26 to allow resident to self administer select medications.
[redacted] 5.27.26

All residents receiving medication administration services had the potential to be affected by improper medication security practices. The residence conducted an audit of medication storage areas, medication carts, and medication handling practices to ensure medications are properly secured and stored in accordance with regulatory requirements.
The residence implemented the following systemic changes:
• Re education of medication technicians and nursing staff regarding medication security, storage, and medication administration procedures.
• Reinforcement of expectations that medications are never left unsecured or unattended.
• Increased oversight of medication pass practices by nursing leadership/designee.
• Review and update of resident care plans regarding self administration status when applicable.
The Administrator/designee or nurse will conduct weekly medication storage and medication pass audits for four weeks, then monthly for three months, to ensure medications are properly secured and handled appropriately. Any

183b Medications and syringes locked (continued)

identified concerns will be corrected immediately and addressed with additional staff education as necessary. Corrective action, staff education, and care plan updates were completed by 4/23/2026. Ongoing monitoring will continue as outlined above.

Proposed Overall Completion Date: 05/29/2026

Directed Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

183e Storing Medications

21. Requirements

2800.
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.

Description of Violation

On 3/4/2026, at approximately 11:50 am, there was a bottle of mi acid/diphenhydramine/lidocaine with a pharmacy label indicating 'swish and spit 10 ml, 3 times daily', in resident #6's resident living unit with an expiration date of 2/16/2026.

Repeat Violation 2/11/2025, et al.

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

The expired medication identified in Resident #6's living unit was removed and properly disposed of in accordance with medication disposal procedures. Resident #6's medication storage practices and self administration status were reviewed to ensure ongoing compliance with medication management requirements. Order from MD received on 4/24/26 to allow resident to self administer select medications.
All residents who self administer medications or maintain medications within their living units had the potential to be affected by improper medication storage practices. The residence conducted an audit of resident medication storage areas and medication expiration dates to identify and remove any expired medications.
The residence implemented the following systemic changes:
• Re education of staff regarding medication storage requirements, expiration date monitoring, and removal of expired medications.
• Reinforcement of procedures for routine inspection of resident medications maintained in living units.
• Implementation of ongoing medication storage audits to ensure medications are organized, current, and properly maintained.
• Increased oversight by nursing leadership/designee regarding medication management practices for residents who self administer medications.
The Administrator/designee or nurse will conduct weekly medication storage and expiration date audits for four weeks, then monthly for three months, to ensure medications are stored appropriately and expired medications are removed timely. Any identified concerns will be corrected immediately and addressed with additional staff education as necessary.
Corrective action, medication audits, and staff education were completed by 4/23/2026.

Licensee's Proposed Overall Completion Date: *05/29/2026*

183e Storing Medications *(continued)*

Implemented ([redacted] - 06/17/2026)

184a Resident meds labeled

22. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

On 3/4/2026, resident #1's Glargine Insulin pen did not have a pharmacy label.

On 3/4/2026, resident #6's Lantus Solostar 100 units/ml pen did not have a pharmacy label.

On 3/4/2026, resident #6's Novolog injection solution pen did not have a pharmacy label.

Repeat Violation- 2/11/2025, et al.

Plan of Correction ***Accept ([redacted] - 05/22/2026)***

Resident #1's Glargine Insulin pen and Resident #6's Lantus Solostar and Novolog insulin pens were immediately reviewed and properly labeled in accordance with pharmacy labeling requirements. Medication storage areas were reviewed to ensure medications were accurately identified and safely maintained.
All residents receiving medication administration services had the potential to be affected by improperly labeled medications. The residence conducted an audit of medication carts, medication rooms, and resident medication supplies to ensure all prescription medications contained appropriate pharmacy labeling.
The residence implemented the following systemic changes:
• Re-education of medication technicians and nursing staff regarding medication labeling requirements under Chapter 2800.
• Reinforcement of procedures requiring verification of pharmacy labeling upon receipt and during medication pass.
• Increased oversight of medication storage and medication administration practices by nursing leadership/designee.
The Administrator/designee or nurse will conduct weekly medication storage and medication pass audits for four weeks, then monthly for three months, to ensure medications are properly labeled and handled appropriately. Any identified concerns will be corrected immediately and addressed with additional staff education as necessary.
Corrective action, medication audits, and staff education were completed by 4/23/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented ([redacted] - 06/17/2026)

185a Storage procedures

23. Requirements

185a Storage procedures *(continued)*

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1 has a physician's order for Lidocaine External Patch 5%, 'apply to skin topically one time a day for pain. Wear no more than 12 hours in a 24 hour period.' This medication was not available in the residence on 3/4/2026.

Resident #9 is prescribed Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 base) MCG/ACT, 2 puffs every 6 hours as needed. This medication was not present in the residence on 3/4/2026.

According to the residence's written "Controlled Substances" policy, "Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises". However, on 1/8/2026, [redacted], former Administrator, whose RN was suspended on that date, went into the medication storage areas on all three floors of the residence and removed and destroyed numerous controlled medications, to include the following:

**1 30ml bottle of Morphine Sulphate 100mg/5ml solution belonging to resident #2*
**24 Lorazepam 1mg tablets belonging to resident #2*
**15 Oxycodone/APAP tab 5-325mg tablets belonging resident #13*

Plan of Correction ***Accept ([redacted] - 05/27/2026)***

Resident #1's Lidocaine Patch was unable to be ordered as resident was discharged on [redacted] and Resident #9's Albuterol inhaler availability were addressed to ensure ordered medications were present 3/23/26 and available for administration as prescribed on . The medication destruction incident involving former Administrator [redacted] was reviewed by current leadership. The individual identified in the citation is no longer employed by the residence. Controlled medication handling practices, medication access, and medication security procedures were reviewed and reinforced with staff.

All residents receiving medication administration services had the potential to be affected by medication availability and medication security concerns. The residence conducted a full audit of medication storage areas, medication carts, controlled substance documentation, medication availability, and staff access practices to ensure compliance with medication management requirements.

The residence implemented the following systemic changes:

• Re-education of medication technicians, nursing staff, and leadership regarding medication security, controlled substance handling, medication availability, and medication storage requirements.
• Reinforcement that only authorized personnel may access medication storage areas and controlled substances.
• Implementation of increased oversight of medication ordering, medication availability, narcotic reconciliation, and medication destruction practices.
• Addition of routine audits for medication storage, controlled substance documentation, medication cart security, and medication availability.

The Administrator/designee or nurse will conduct weekly medication storage and medication pass audits for four weeks, then monthly for three months, to ensure medications are properly labeled and handled appropriately. Any identified concerns will be corrected immediately and addressed with additional staff education as necessary. Corrective action, medication audits, policy review, and staff education were completed by 4/23/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 06/17/2026)

187a Medication record

24. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
4. Strength.

Description of Violation

Resident #1 is prescribed Tacrolimus 1 mg capsule, take 1 capsule by mouth twice daily at 7 am and 8 pm; however, resident #1's March 2026 medication administration record (MAR) did not indicate the strength of the medication.

Plan of Correction ***Accept ([redacted] - 05/22/2026)***

Resident #1's March 2026 MAR was reviewed, resident was d/c from facility on [redacted] unable to revise MAR.
All residents receiving medication administration services had the potential to be affected by incomplete MAR documentation. The residence conducted an audit of current MARs to ensure medication strength and all other required medication information were accurately documented.
The residence implemented the following systemic changes:
• Re-education of medication technicians and nursing staff regarding MAR documentation requirements under Chapter 2800.
• Reinforcement of procedures requiring review of MAR entries for completeness and accuracy prior to medication administration.
• Increased oversight by nursing leadership/designee regarding MAR documentation compliance.
The Administrator/designee or nurse will conduct weekly medication storage and medication pass audits for four weeks, then monthly for three months, to ensure medications are properly labeled and handled appropriately. Any identified concerns will be corrected immediately and addressed with additional staff education as necessary.
Additionally, MAR documentation audits will be completed weekly for four weeks, then monthly for three months, to ensure all required medication information is accurately documented.
Corrective action, MAR audits, and staff education were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented ([redacted] - 06/17/2026)

187d Follow prescriber's orders

25. Requirements

2800.
187.d. The residence shall follow the directions of the prescriber.

Description of Violation

Resident #1 has a physician's order for Lidocaine External Patch 5%, 'apply to skin topically one time a day for pain. Wear no more than 12 hours in a 24 hour period.' However, resident #1 did not receive this medication on numerous dates due to the medication not being in the home, to include 2/1/2026-2/3/2026. Nursing staff at the residence entered "HOLD" into Resident #1's February 2026 MAR because the medication was not available; however, there was no hold order from a licensed provider.

On the evening of 2/4/2026, resident #2's [redacted] requested that resident #2 receive doses of the following

187d Follow prescriber's orders (continued)

prescribed PRN medications: Lorazepam 1 mg 'give 1 by mouth every 4 hours as needed for anxiety' and Morphine Sulfate 20 mg/5ml 'give 10 milligrams sublingually every 2 hours as needed for pain/dyspnea'; however, the medications were not available in the residence because they had been removed and destroyed by [redacted], the residence's former Administrator. Resident #2 was experiencing difficulty breathing, and had a pulse oximetry reading of 81 %. Resident #2 was discharged from hospice and admitted to the hospital the next morning for treatment of these persistent symptoms.

Repeat Violation- 6/3/2025

Plan of Correction ***Accept ([redacted] - 05/22/2026)***

Resident #1's medication orders and MAR documentation were reviewed but unable to be corrected due to resident being d/c on [redacted] Staff were instructed that medications may not be placed on hold without a licensed provider order. Resident #2's medication concerns and medication availability issues were reviewed by current leadership. The former Administrator identified in the citation is no longer employed by the residence. Medication ordering, medication availability, and controlled substance management practices were immediately reviewed and reinforced with staff to ensure prescribed medications remain available for resident use.

All residents receiving medication administration services had the potential to be affected by medication availability concerns or failure to follow prescriber orders. The residence conducted an audit of physician orders, MAR documentation, medication availability, and controlled substance records to identify and correct any additional discrepancies.

The residence implemented the following systemic changes:

• Re-education of medication technicians and nursing staff regarding following prescriber orders, proper MAR documentation, medication availability monitoring, and provider notification requirements.

• Reinforcement that medications may not be placed on hold without a provider order.

• Increased oversight of medication ordering processes to ensure medications are available and reordered timely.

• Review and reinforcement of medication management and controlled substance policies with all applicable staff.

The Administrator/designee or nurse will conduct weekly medication storage and medication pass audits for four weeks, then monthly for three months, to ensure medications are properly labeled and handled appropriately. Any identified concerns will be corrected immediately and addressed with additional staff education as necessary.

Additionally, MAR documentation, medication availability, and physician order audits will be completed weekly for four weeks, then monthly for three months, to ensure prescriber orders are followed accurately and medications remain available for administration.

Corrective action, medication audits, policy review, and staff education were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented ([redacted] - 06/17/2026)

224a2 30 days prior to admission

26. Requirements

2800.
224.a.2. An individual shall have a written initial assessment that is documented on the Department's assessment form within 30 days prior to admission unless one of the conditions contained in paragraph (3) apply.

Description of Violation

Resident #1 was admitted to the residence on [redacted]. Resident #1's records do not include a written preliminary

224a2 30 days prior to admission (continued)

initial assessment completed within 30 days prior to admission.

Plan of Correction ***Accept (- 05/22/2026)***

Resident #1's admission records were reviewed, however unable to backdate preliminary assessment due to d/c from facility on The residence reviewed the admission process with responsible staff to reinforce requirements for completion of initial assessments prior to admission.
All residents admitted to the residence had the potential to be affected by incomplete or missing admission assessment documentation. The residence conducted an audit of admission records to ensure required initial assessments were completed and maintained in accordance with regulatory requirements.
The residence implemented the following systemic changes:
• Re-education of admissions, nursing, and leadership staff regarding initial assessment requirements under Chapter 2800.
• Increased oversight of the admission process and resident record review by leadership/designee.
• Addition of admission documentation reviews to routine chart audits.
The Administrator/designee or nurse will audit all new admission records weekly for four weeks, then monthly for three months, to ensure required assessments and admission documentation are completed timely and maintained appropriately. Any identified deficiencies will be corrected immediately and addressed with additional staff education as necessary.
Corrective action, record audits, and staff education were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 06/17/2026)

224a5 Written initial assessment

27. Requirements

2800.
224.a.5. The written initial assessment must, at a minimum include the following:
i. The individual's need for assistance with ADLs and IADLs.
iii. The ability of the individual to self-administer medication.
iv. The individual's medical history, medical conditions, and current medical status and how they impact or interact with the individual's service needs.

Description of Violation

Resident #1 was admitted to the residence on Resident #1's undated assessment and support plan that is indicated to be the resident's initial assessment is blank in numerous areas to include transferring, bladder management, bowel management, ambulating, and the resident's ability to self-administer medications.

Resident #1's medical evaluation, dated indicates diagnoses of bipolar disorder and generalized anxiety disorder; however, these diagnoses are not included on Resident #1's undated assessment and support plan that is indicated to be the resident's initial assessment.

Repeat Violation- 2/11/2025, et al.

224a5 Written initial assessment *(continued)*

Plan of Correction ***Accept (- 05/22/2026)***

Resident #1's assessment and support plan were reviewed, however unable to backdate preliminary assessment due to d/c from facility on

All residents admitted to the residence had the potential to be affected by incomplete assessment documentation.

The residence conducted an audit of resident assessments and support plans to ensure required sections were completed accurately and reflected current resident needs and diagnoses.

The residence implemented the following systemic changes:

• Re education of nursing, admissions, and leadership staff regarding assessment completion requirements under Chapter 2800.

• Increased oversight by leadership/designee regarding admission assessments, support plans, and resident record documentation.

• Addition of assessment and support plan reviews to routine chart audits.

The Administrator/designee or nurse will audit resident assessments and support plans weekly for four weeks, then monthly for three months, to ensure assessments are complete, accurate, and reflective of resident needs and diagnoses. Any identified deficiencies will be corrected immediately and addressed with additional staff education as necessary.

Corrective action, record audits, and staff education were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 06/17/2026)

224c1 Initial SP-30 days prior/adm

28. Requirements

2800.

224.c.1. An individual requiring services shall have a written preliminary support plan developed within 30 days prior to admission to the residence unless one of the conditions contained in paragraph (2) applies.

Description of Violation

Resident #1 was admitted on however, the resident's support plan that is indicated to be the initial support plan is undated and is blank in numerous areas, to include supervision and medications.

Resident #8 was admitted to the residence on however, resident #8 did not have an initial/preliminary support plan developed within 30 days prior to admission to the residence.

Plan of Correction ***Accept (- 05/27/2026)***

Resident #1's support plan was reviewed, unable to retroactively obtain initial support plan, resident records were audited for completeness and accuracy. Resident #8's support plan was unable to be retroactively initiated.

All residents admitted to the residence had the potential to be affected by incomplete or missing preliminary support plans. The residence conducted an audit of resident admission records and support plans to ensure required plans were completed timely and contained all required information.

The residence implemented the following systemic changes:

• Re education of admissions, nursing, and leadership staff regarding preliminary support plan requirements under

224c1 Initial SP 30 days prior/adm (continued)

Chapter 2800.

• Increased oversight by leadership/designee regarding review of admission documentation and support plans.

• Addition of support plan reviews to routine chart audits.

The Administrator/designee or nurse will audit all new admission records and support plans weekly for four weeks, then monthly for three months, to ensure required support plans are completed timely and contain all required information. Any identified deficiencies will be corrected immediately and addressed with additional staff education as necessary.

Corrective action, record audits, and staff education were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 06/17/2026)

225a1 Assessment – annually

29. Requirements

2800.

225.a.1. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: Annually.

Description of Violation

Resident #3's most recent assessment was dated [redacted]

Resident #4's most recent assessment was dated [redacted]

Resident #5's most recent assessment was dated [redacted]

Resident #7's most recent assessment was dated [redacted]

Plan of Correction ***Accept (- 05/22/2026)***

Resident #3, Resident #5, and Resident #7 were scheduled for updated annual assessments to ensure compliance with regulatory requirements. Resident # 4 d/c from facility on [redacted] *unable to be updated. Resident records were reviewed and updated accordingly to reflect current resident needs and services.*

All residents residing within the residence had the potential to be affected by overdue annual assessments. The residence conducted an audit of resident assessment dates to identify any additional residents requiring updated annual assessments.

The residence implemented the following systemic changes:

• Development of a tracking system to monitor annual assessment due dates.

• Re education of nursing and leadership staff regarding annual assessment requirements under Chapter 2800.

• Increased oversight of resident record compliance through routine chart audits.

The Administrator/designee or nurse will audit resident assessment dates weekly for four weeks, then monthly for three months, to ensure annual assessments are completed timely and maintained in resident records. Any identified deficiencies will be corrected immediately and addressed with additional staff education as necessary.

225a1 Assessment – annually (continued)

Corrective action, record audits, and staff education were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 06/17/2026)

227a Final support plan – 30 days

30. Requirements

2800.
227.a. Each resident requiring services shall have a written final support plan developed and implemented within 30 days after admission to the residence. The final support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted to the residence on [redacted] however, the resident's support plan that is indicated to be the initial/final support plan is undated and is blank in numerous areas, to include supervision and medications.

On 3/2/2026, a bedside mobility device was present on resident #3's bed: however, resident #3's most recent support plan, dated [redacted] does not include the specific need for the device, the intended use and any risk associated with the use or resident #3's ability to use the device safely for the purpose it was intended.

Resident #8 was admitted to the residence on [redacted] however, the resident's initial support plan was completed on [redacted]

Plan of Correction ***Accept (- 05/22/2026)***

Resident #1'was reviewed, however unable complete new assessment due to d/c from facility on [redacted] Resident #3's support plan was updated to reflect the resident's bedside mobility device, including the purpose of the device, associated risks, and the resident's ability to use the device safely. Resident #8's support plan was reviewed and was late however we are unable to backdate initial support plan. Resident records were audited for accuracy and completeness.
All residents requiring services had the potential to be affected by incomplete, missing, or untimely support plans. The residence conducted an audit of resident support plans to ensure plans were completed timely, accurately reflected resident needs, and included
The residence implemented the following systemic changes:
• Re-education of nursing, admissions, and leadership staff regarding final support plan requirements under Chapter 2800.
• Increased oversight by leadership/designee regarding completion and review of support plans within required timeframes.
• Addition of support plan reviews to routine chart audits to ensure ongoing compliance.
The Administrator/designee or nurse will audit all new admission records, assessments, and support plans weekly for four weeks, then monthly for three months, to ensure required support plans are completed timely and contain all required information. Any identified deficiencies will be corrected immediately and addressed with additional staff education as necessary.
Corrective action, record audits, support plan updates, and staff education were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

227a Final support plan – 30 days (continued)

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 06/18/2026)

227c Final support plan - revision

31. Requirements

2800.
227.c. The final support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

Resident #1, admitted on has not had a quarterly review of undated initial support plan.

Resident #2 began receiving hospice services on ; however, the information for the hospice provider and the service needs the provide is not included on resident #2's support plan, dated , and there have been no quarterly reviews.

Resident #4's most recent support plan was dated

Resident #5's most recent support plan is dated and only had quarterly reviews dated and .

Plan of Correction ***Accept (- 05/22/2026)***

Resident #1's support plan was reviewed; however resident was d/c from facility on unable to backdate reviews. Resident #2's support plan was unable to be revised due to resident CTB on . Resident #4 unable to be updated due to be updated due to d/c on and Resident #5's support plans were reviewed and updated to ensure current resident needs, services, and quarterly review requirements were accurately reflected. Resident records were audited for completeness and accuracy.

All residents residing within the residence had the potential to be affected by incomplete or overdue support plan reviews and revisions. The residence conducted an audit of resident support plans, quarterly reviews, and significant change documentation to identify and correct any additional deficiencies.

The residence implemented the following systemic changes:

• Development of a tracking system for quarterly support plan reviews and annual updates.

• Re-education of nursing and leadership staff regarding support plan review, revision, and documentation requirements under Chapter 2800.

• Increased oversight by leadership/designee regarding resident record compliance and timely completion of support plan revisions.

• Addition of support plan reviews to routine chart audits.

The Administrator/designee or nurse will audit resident support plans and quarterly review documentation weekly for four weeks, then monthly for three months, to ensure reviews and revisions are completed timely and accurately reflect resident needs and services. Any identified deficiencies will be corrected immediately and addressed with additional staff education as necessary.

Corrective action, record audits, support plan updates, and staff education were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

227c Final support plan - revision (continued)

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 06/17/2026)

227g Support plan - signatures

32. Requirements

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1's undated support plan indicated to be the initial support plan was not signed or dated by the assessor and was not dated by the resident.

Resident #11's annual support plan, dated 1/14/2026, was not signed or dated by the resident or designated person.

Repeat Violation- 4/10/2025, et al.

Plan of Correction ***Accept (- 05/22/2026)***

Resident #11's annual support plan was reviewed and updated to obtain required signatures and dates from the resident and/or designated person as applicable. Resident records were reviewed for completeness and compliance. All residents residing within the residence had the potential to be affected by incomplete support plan signature and dating requirements. The residence conducted an audit of resident support plans to ensure all required participant signatures and dates were present and complete.
The residence implemented the following systemic changes:
• Re-education of nursing and leadership staff regarding support plan signature and documentation requirements under Chapter 2800.
• Increased oversight by leadership/designee regarding review of support plans for completeness and compliance.
• Addition of support plan signature verification to routine chart audits.
The Administrator/designee or nurse will audit resident support plans weekly for four weeks, then monthly for three months, to ensure all required signatures and dates are completed timely and accurately. Any identified deficiencies will be corrected immediately and addressed with additional staff education as necessary.
Corrective action, record audits, support plan updates, and staff education were completed by 5/15/2026. Ongoing monitoring will continue as outlined above.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 06/17/2026)