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

August 27, 2026

[redacted], VP OF OPERATION
EMBASSY DARLINGTON LLC
[redacted]

RE: LAKEVIEW PERSONAL CARE
498 LISBON ROAD
DARLINGTON, PA, 16115
LICENSE/COC#: 45161

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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: *LAKEVIEW PERSONAL CARE* **License #**: *45161* **License Expiration**: *06/17/2026*

Address: *498 LISBON ROAD, DARLINGTON, PA 16115*

County: *BEAVER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *EMBASSY DARLINGTON LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/23/1992* **Issued By**: *Dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *35* **Waking Staff**: *26*

Inspection Information

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

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

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *92* **Residents Served**: *32*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *32*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *3* **Have Physical Disability**: *1*

Inspections / Reviews

03/03/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/27/2026*

03/30/2026 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/06/2026*

Inspections / Reviews *(continued)*

03/31/2026 POC Submission

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

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

08/27/2026 Document Submission

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

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 3/3/26 at approximately 09:30 a.m., the A-Hall nurse station was unlocked, accessible, and unattended with multiple hospice resident records with treatment plan, physicians orders, and care notes.

Plan of Correction ***Accept (- 03/30/2026)***

All resident records observed unsecured at the A-Hall nurse station were immediately secured upon discovery on March 3, 2026.

On March 4, 2026 all treatment carts, Hospice and Home Health agencies resident charts were removed from the area and relocated to a secured office next to the nurses office and med room.

On March 5, 2026, all nursing staff were re-educated on resident confidentiality requirements, including proper handling and secure storage of medical records.

Facility policy regarding safeguarding resident records was reviewed and reinforced.

will conduct random audits of nurse stations weekly for four (4) weeks, then monthly for two (2) months to ensure ongoing compliance. Findings will be documented, and corrective action will be taken immediately if non-compliance is identified. An audit sheet shall be kept.

All corrective actions and staff education were completed March 4, 2026.

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

Implemented (- 06/10/2026)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #3 was admitted into the home on ; however, the resident, administrator and designee did not sign the contract until

Plan of Correction ***Accept (- 03/30/2026)***

On March 3, the contract for Resident #3 has been fully executed as of

On March 20, 2026 the Administrator, conducted an audit of all current resident records to ensure that admission contracts were signed on or before the date of admission. Any discrepancies identified were immediately corrected, and missing or delayed signatures were obtained.

25b - Contract Signatures (continued)

By March 5, 2026 the facility is implementing a revised admission procedure requiring that all contracts be reviewed and signed by the resident, administrator, and Responsible Person, at the time of admission, prior to or upon entry into the home.

A standardized admission checklist has been developed and must be completed before the admission process is finalized.

Beginning March 20, 2026, the Administrator, [redacted] will review all new admissions weekly for a period of 30 days to ensure compliance. After 30 days, monitoring will be conducted monthly. Any discrepancies will be addressed immediately, and additional staff training will be provided as needed.

All corrective actions will be completed by March 20, 2026.

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

Implemented ([redacted] - 06/10/2026)

51 - Criminal Background Check

3. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A was hired on [redacted] however, a criminal history background check was not completed.
Staff person B was hired on [redacted] however, a criminal history background check was not completed.
Staff person C was hired on [redacted]; however, a criminal history background check was not completed until [redacted]
Direct care staff person D, hired [redacted] did not hold permanent residency in Pennsylvania for two consecutive years prior to employment; however, a FBI background check was not completed in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. § 10225.101-10225.5102) and 6 Pa. Code Chapter 15.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On March 4, 2026, Staff A and Staff B: Criminal history background checks were completed. If results are not received within the required timeframe, both employees will be removed from direct care duties until compliance is verified.

Staff C: A criminal history background check was completed on March 4, 2026. Documentation has been reviewed and placed in the employee's personnel file.

Staff D: An FBI criminal background check will be completed immediately due to non-residency in Pennsylvania for the required two-year period.

Staff D will be removed from direct care duties until results are received and reviewed.

On March 4, 2026 a 100% audit of all employee personnel files was conducted to verify compliance with:

51 - Criminal Background Check (continued)

Pennsylvania State Police (PATCH) checks

FBI background checks for non-PA residents

Any deficiencies identified will be corrected immediately, and affected staff will be removed from duty until compliant.

The facility will implement a revised hiring policy requiring:

Completion and verification of all required background checks prior to the first day of employment.

A pre-employment checklist will be required and signed off by Human Resources before any new hire begins work.

The Administrator [redacted] will conduct monthly audits of newly hired employee files for 3 months and quarterly audits thereafter to ensure sustained compliance. An audit sheet shall be kept.

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

Implemented ([redacted] - 06/10/2026)

65e - 12 Hours Annual Training

4. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Staff person C, hired on [redacted],completed 8hours, 40 minutes of the required 12 annual training hours in the 2025 training year.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On Staff Person C will complete the remaining required training hours to meet the 12-hour annual training requirement. All outstanding training will be completed no later than March 20,2026.

Beginning March 4, 2026 the Wellness Director [redacted] will conduct quarterly audits of training records to ensure all direct care staff are meeting the annual 12-hour requirement. Any discrepancies will be addressed immediately.
An audit sheet shall be kept.
The initial audit will be completed by March 20, 2026.

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

Implemented ([redacted] - 06/10/2026)

65f - Training Topics

5. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff person C, hired on [redacted] did not receive the following required training topics in the training year 2025:
Medication self-administration training
Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
Infection control
Safe management techniques
Care for residents with mental illness and mental retardation.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

By March 5, 2026, Staff person C will complete all missing required training topics. Documentation of completion will be maintained in the employee's personnel file.

Beginning March 3, 2026 the Wellness Director [redacted] will conduct an audit of all staff training records to ensure compliance with required annual training topics.

Beginning March 3, 2026, the training requirements will be reviewed monthly by the HR Director [redacted] to ensure all staff remain compliant. An audit sheet shall be kept.

All corrective actions will be completed by March 20, 2026.

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

Implemented ([redacted] - 06/10/2026)

65g - Annual Training Content

6. Requirements

2600.
65.g. 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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.

65g - Annual Training Content *(continued)*

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person D, hired on [redacted] did not receive the following required training topics in the training year 2025:
Fire safety completed by a fire safety expert
Emergency preparedness
Falls and accident prevention
staff person C, hired on [redacted], did not receive the following required training topics in the training year 2025:
Fire safety completed by a fire safety expert
Emergency preparedness
Resident Rights
The Older Adult Protective Services Act

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On March 4, 2026 Staff Person D, hired on [redacted], completed all of the required trainings for 2025.
Fire safety completed by a fire safety expert
Emergency preparedness
Falls and accident prevention

On March 4, 2026 Staff person C, hired on [redacted], completed all of the required trainings for 2025.
Fire safety completed by a fire safety expert
Emergency preparedness
Falls and accident prevention
The Older Adult Protective Services Act

Completion of each training has been documented in their staff training records.

Beginning 4/1/26, The Wellness Director [redacted] along with the HR Director [redacted] is completing a quarterly training audit to ensure all required trainings are completed timely for all staff. An audit sheet shall be kept.

On March 3, 2026 the HR Director [redacted] completed a complete audit of all staff records to ensure that all trainings are complete for each staff member. An audit sheet shall be kept.

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

Implemented ([redacted] - 06/10/2026)

91 - Telephone Numbers

7. Requirements

2600.

91 - Telephone Numbers *(continued)*

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

The telephone numbers for for emergency management and for personal care home complaint hotline were not posted nearby any of the resident bedroom telephones with an outside line, to include:
Resident #1
Resident #2
Resident #3
Resident #4

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On March 4, 2026, the Maintenance Director [redacted] posted the required telephone numbers in a clearly visible location near each resident room.

The Administrator [redacted] verified that all old posted numbers were removed and are now current and accurate.

Beginning 4/4/22026 the Maintenance Director [redacted] will perform a weekly audit of resident room telephone postings to ensure all required emergency and complaint hotline numbers remain posted and visible. An audit sheet shall be kept.

On 4/6/26 all staff were re-educated on the requirement to maintain posted emergency contact information in all resident areas with telephones that have outside lines.

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

Implemented ([redacted] - 06/10/2026)

95 - Furniture and Equipment

8. Requirements

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

Description of Violation

The elevator lift from the 1st floor to the lower level was inoperable.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

A licensed elevator service technician was contacted on March 3, 2026 to inspect and repair the elevator.

The elevator will remain out of service until repairs are completed and it passes all safety inspections.

The corporate office is currently working with our legal team to expedite the repairs that are needed for proper

95 Furniture and Equipment (continued)

operation of the "Lift".

Beginning March 3, 2026 The Administrator [redacted] is continuing to maintain documentation of inspections, maintenance, and repairs to ensure compliance with safety regulations.

As this is a warranty issue with the manufacturer of the lift unit and the installers (Access Elevator) I do have a date of when the unit will be repaired.

The Administrator [redacted] is responsible for overseeing the repairs are completed as soon as possible.

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

Implemented ([redacted] - 06/10/2026)

99 - Indoor/Outdoor Recreation

9. Requirements

2600.
99. Recreation Space - The home shall provide regular access to outdoor recreation space and recreational items, such as books, newspapers, magazines, puzzles, games, cards and crafts.

Description of Violation

Multiple residents reside on the lower level, including resident #4, who rely on the elevator lift or require assistance in climbing stairs. Since December 2025, the elevator lift has been inoperable and residents are unable to access the homes daily activities being held on the second floor.

Plan of Correction ***Accept ([redacted] - 03/31/2026)***

On December 5, 2025 the Administrator [redacted] reported the elevator malfunction to the service provider (Access Elevator).

Beginning March 4, 2026 the Activity Director [redacted] is coordinating the scheduling of activities for the lower level and offering transport to the upper level activity room for any programming that they desire to attend.

Beginning March 5, 2026, the Activity Director [redacted] began relocation of essential activities to the lower level to ensure continued participation.

On March 5, 2026 all residents and families were informed of the issue and temporary accommodations.

Beginning March 4, 2026 the Administrator [redacted] will contact the corporate legal team weekly to check on the status of the repairs. This will be logged until the repairs are completed.

Beginning March 4, 2026 the Activity Director [redacted] is coordinating the scheduling of activities for the lower level and offering transport to the upper level activity room for any programming that they desire to attend.

99 - Indoor/Outdoor Recreation *(continued)*

Licensee's Proposed Overall Completion Date: *03/30/2026*

Implemented ([redacted] - 06/10/2026)

101j7 - Lighting/Operable Lamp

10. 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

At approximately 10:15 a.m., resident #2 operable lamp was approximately 5 feet from bedside.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

Immediate Correction: Staff immediately repositioned the lamp within reach of resident #2's bedside to ensure safe and easy access.

Staff Education: All direct care staff were re-educated on ensuring bedside items, including lamps, are accessible to residents at all times. Education included proper placement of lamps and other frequently used items to prevent safety hazards.

The Maintenance Director [redacted] will conduct daily rounds for one week to verify that all bedside lamps are properly positioned.

Beginning March 4, 2026, random audits will be conducted weekly for one month to ensure ongoing compliance. An audit sheet shall be kept.

All immediate corrections were completed on March 3, 2026. All staff were educated on March 4, 2026.

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

Implemented ([redacted] - 06/10/2026)

103f - Refrigerator/Freezer Temps

11. 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

At approximately 10:00 a.m., the thermometer in freezer #3 in the lower-level dry food storage room was inoperable.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On March 3, 2026, the inoperable thermometer was immediately removed from service.

A replacement thermometer was installed in Freezer #3 on March 3, 2026.

On March 3. 2026, the temperature readings were verified to ensure the freezer is maintaining proper storage temperatures.

103f - Refrigerator/Freezer Temps (continued)

On March 3, 2026 all food items in the freezer were inspected; no temperature violations were noted.

Beginning March 3, 2026, the Dining Services Manager [redacted] *will perform weekly inspection schedule for all freezer and refrigerator thermometers to ensure they are functioning correctly. An audit sheet shall be kept.*

On March 3, 2026 all dietary staff were inserviced on the importance of monitoring and reporting malfunctioning thermometers immediately.

On March 4, 2026 three spare thermometers were purchased and are being kept on-site for immediate replacement if a device becomes inoperable.

Beginning March 4, 2026, The Dining Services Manager [redacted] *will perform a daily and weekly thermometer checks. An audit sheet shall be kept.*

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

Implemented ([redacted] - 06/10/2026)

127a - Portable Space Heaters

12. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

At approximately 11:00 a.m., two space heaters were stored on a counter in the lower-level maintenance room of the home.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On March 3, 2026 the space heaters were immediately removed from the counter and thrown into the dumpster.

On March 4, 2026, the Administrator [redacted] *inserviced the staff that portable space heaters are prohibited in the community.*

Beginning March 4, 2026 the Maintenance Director [redacted] *will perform a weekly audit of the community for four weeks, to ensure that no space heaters are being utilized or stored within the community and remove any units from the community if they are found. An audit sheet shall be kept.*

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

Implemented ([redacted] - 06/10/2026)

131f - Fire Extinguisher Inspection

13. Requirements

131f Fire Extinguisher Inspection *(continued)*

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

All fire extinguishers inside the home, with the exception of the extinguisher in the activity room, have not been inspected since 12/2024, and were observed in the following locations:
Check A-wing of the home (2)
C wing (2)
Main entrance hallway
D-7 Dining room (2)
Kitchen (2)

Plan of Correction ***Accept (- 03/30/2026)***

On March 4, 2026 the Maintenance Director [redacted] performed an immediate Inspection of all fire extinguishers to ensure all are in proper working condition. All were found to be in good condition.

On March 4, 2026 the Maintenance Director [redacted] contacted the communities fire monitoring company [redacted] to schedule and complete inspection of all affected fire extinguishers by April 1, 2026.

Beginning March 4, 2026 the Maintenance Director [redacted] will perform a monthly inspection of the fire extinguishers and report any error in in inspection dates to Fire Foe for immediate inspection. An audit sheet shall be kept.

Beginning April1, 2026, the communities fire monitoring company [redacted] are scheduled quarterly to return, inspect, date, and inspect the communities fire extinguishers.

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

Implemented (- 06/10/2026)

141b1 Annual Medical Evaluation

14. Requirements

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

Description of Violation

Resident #4's most recent medical evaluation completed and signed by a provided was dated [redacted]

Resident #2's most recent medical evaluation was completed [redacted] however, the previous medical evaluation was completed [redacted]

Plan of Correction ***Accept (- 03/30/2026)***

On March 5, 2026the Wellness Director [redacted] performed a review of all current residents' medical

141b1 - Annual Medical Evaluation (continued)

evaluation dates were current and to identify any overdue or late evaluations.

On March 5, 2026the Wellness Director [redacted] ensured completion of any missing or outdated evaluations of any resident lacking a current evaluation and scheduled immediately for completion by a licensed provider on March 9, 2026.

On March 5, 2026 the Wellness Director [redacted] retrained the staff on timely completion and documentation of required medical evaluations per facility policy and regulatory standards.

On March 5, 2026 the Wellness Director [redacted] created an audit tool to track evaluation due dates and ensure completion within the required timeframes.

On March 5, 2026the Wellness Director [redacted] will conduct monthly audits to verify all residents have current medical evaluations documented and signed by a licensed provider. An audit sheet shall be kept.

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

Implemented ([redacted] - 06/10/2026)

171b5 - First Aid Kit

15. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the home passenger lift van did not include a thermometer, tweezers, or eye protection.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

Immediate Action:

On March 4, 2026 the Maintenance Director [redacted] procured a thermometer, tweezers, and eye protection and placed them in the first aid kit.

On March 4, 2026 the Maintenance Director [redacted] verified that all other essential first aid items are present and in usable condition.

On March 4, 2026 the Maintenance Director [redacted] created a monthly audit sheet for four months, to inspect the van first aid kit to ensure that all required items are present.

On March 5, 2026 the Administrator [redacted] educated staff all staff members of the updated first aid kit contents.
Staff were trained to report missing or expired items immediately.

171b5 - First Aid Kit *(continued)*

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

Implemented ([redacted] - 06/10/2026)

183b - Meds and Syringes Locked

16. 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 3/3/26 at approximately 09:30 a.m., the treatment medication cart in the A-Hall nurses stations was unlocked, accessible, unattended with multiple residents to include resident #5's and resident #6's lotion, creams, shampoos to include Voltaren Arthritis Pain Gel (1% Diclofenac Sodium).

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On March 3, 2026All resident records observed unsecured at the A-Hall nurse station were immediately secured upon discovery.

On March 4, 2026 all treatment carts, Hospice and Home Health agencies resident charts were removed from the area and relocated to a secured office next to the nurses office and med room.

On March 5, 2026, the Wellness Director [redacted] re-educated all nursing staff that any cart must be locked, inaccessible, and must be attended at all times when staff is not present. including proper handling and secure storage of resident treatment items.

Beginning March 5, 2026, the Wellness Director [redacted] will conduct random audits of nurse stations weekly for four (4) weeks, then monthly for two (2) months to ensure ongoing compliance. An audit sheet shall be kept.

All corrective actions and staff education were completed on March 4, 2026.

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

Implemented ([redacted] - 06/10/2026)

224b - Assessment Referral

17. Requirements

2600.
224.b. An applicant whose personal care service needs cannot be met by the home shall be referred to a local appropriate assessment agency.

Description of Violation

Resident #4's preadmission screening, completed [redacted] did not indicated whether the home could meet the resident needs and it is missing page two of the form.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On March 5, 2026, the Wellness Director [redacted] located the missing page of the preadmission screening form for Resident #4.

224b Assessment Referral (continued)

The form was reviewed to ensure all sections, including assessment of the facility's ability to meet resident needs, were completed accurately.

On March 5, 2026, the Wellness Director [redacted] was immediately educated on completing the forms fully and accurately and ensuring that all pre screeners are placed in the appropriate residents file.

On March 5, 2026, the Wellness Director [redacted] audited all current residents' preadmission screening forms to ensure all pages are present, completed and accurate.

Beginning March 5, 2026, the Wellness Director [redacted] will audit 100% of new preadmission screening forms for completeness for 90 days. Review will be kept via audit tool.

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

Implemented ([redacted] - 06/10/2026)

225a - Assessment 15 Days

18. Requirements

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

Description of Violation

The assessment for resident #1, dated [redacted] was blank in the behavioral and cognitive section.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On March 5, 2026, the Wellness Director [redacted] reviewed the behavioral and cognitive section for Resident #1 has been completed and signed.

On March 5, 2026, the Wellness Director [redacted] provided re education to all nursing staff on the importance of completing all sections of the resident assessment.

On March 5, 2026, the Wellness Director [redacted] Implemented a monthly audit of newly completed assessments to ensure completeness before submission. Tracking will be kept via Audit tool. An audit sheet shall be kept.

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

Implemented ([redacted] - 06/10/2026)

227b - Support Plan Content

19. Requirements

227b - Support Plan Content *(continued)*

2600.
227.b. A home may use its own support plan form if it includes the same information as the Department's support plan form.

Description of Violation

The assessment, dated [redacted] indicates resident #4's social and recreational needs included Bible study/bingo. The support plan indicates direct care staff and family will ensure this resident "makes it to activities and Bible study, church"; however, this resident has not been able to participate in this activity as the homes elevator lift has been broken since approximately November 2025. The [redacted] support plan included an addendum, dated [redacted] indicating this resident would require assistance with stairs and activities to address church being downstairs in case of event elevator is out of order to ensure safety. However, this information was not reflected on the current assessment and support plan.
REPEAT VIOLATION: 3/6/25 et al

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On March 5, 2026, the Wellness Director [redacted] performed an Immediate review and update of Resident #4's current assessment and support plan to include:

Assistance with stairs when the elevator is out of service.

On March 5, 2026, the Wellness Director [redacted] reviewed the procedures with the Activities Director [redacted] to ensure participation in Bible study, bingo, and church activities.

On March 5, 2026, the Wellness Director [redacted] inserviced the care staff to provide the necessary assistance to activities.

Beginning March 5, 2026 the care staff will ensure daily checks for resident participation in activities.

Beginning March 5, 2026 the Wellness Director [redacted] will audit the updated support plan for accuracy and completeness weekly for four weeks.

Beginning March 5, 2026 the Wellness Director [redacted] and the Administrator [redacted] will perform quarterly reviews of all residents' social and recreational support plans and will include verification that mobility needs are accurately documented, including elevator outages or stair assistance requirements.

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

Implemented ([redacted] - 06/10/2026)

227g -Support Plan Signatures

20. Requirements

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

227g Support Plan Signatures *(continued)*

Description of Violation

Resident #3's support plan completed [redacted] does not indicate the date the assessor and resident sign the support plan.

Plan of Correction ***Accept ([redacted] - 03/30/2026)***

On March 5, 2026 the Wellness Director [redacted] updated resident #3's support plan, to indicate the dates when the assessor and the resident signed the plan.

On March 5, 2026 the Wellness Director [redacted] reeducated the Supervisors and care staff to review the support plans immediately and document any missing signature dates.

On March 5, 2026 the Wellness Director [redacted] All staff responsible for completing support plans were retrained on the requirement to include signature dates for both the assessor and the resident on every support plan.

Beginning March 5, 2026 the Wellness Director [redacted] will audit 100% of newly completed support plans weekly for the next 4 weeks to ensure signature dates are documented correctly. Any missing signatures will be immediately corrected and reported to the Administrator [redacted] A audit sheet shall be kept.

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

Implemented ([redacted] - 06/10/2026)