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

June 2, 2026

[redacted], ADMINISTRATOR
CLARKS SUMMIT AID II OPCO LLC
150 EDELLA ROAD
CLARKS SUMMIT, PA, 18411

RE: WILLOWBROOK PLACE
150 EDELLA ROAD
CLARKS SUMMIT, PA, 18411
LICENSE/COC#: 22659

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/04/2026, 03/12/2026 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: *WILLOWBROOK PLACE* **License #**: *22659* **License Expiration**: *01/08/2027*

Address: *150 EDELLA ROAD, CLARKS SUMMIT, PA 18411*

County: *LACKAWANNA* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *CLARKS SUMMIT AID II OPCO LLC*

Address: *150 EDELLA ROAD, CLARKS SUMMIT, PA, 18411*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/10/1996* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *43* **Total Daily Staff**: *96* **Waking Staff**: *72*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *03/12/2026*

Inspection Dates and Department Representative

03/04/2026 - On-Site: [redacted]

03/12/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *43*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *45*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *10* **Have Physical Disability**: *0*

Inspections / Reviews

03/04/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/13/2026*

04/13/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/23/2026*

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

Inspections / Reviews *(continued)*

04/16/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/23/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/27/2026*

06/02/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/23/2026*

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

25c8 - Smoking

1. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
8. The home's rules related to home services, including whether the home permits smoking.

Description of Violation

The resident-home contract dated [redacted] for Resident #1 does not include the current home rule for smoking. The contract indicates the property is smoke free and smoking is prohibited. However, there is a smoking area off the back deck of the home.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

• Immediate Resolution: The resident contract will be immediately reviewed and revised to accurately reflect the current smoking policy. New admissions will receive the updated contract moving forward and a 30-day notice of any changes to the contract.
• Training: Staff will be educated by 4/17/2026 on the updated policy to ensure consistent communication and enforcement.
• Monitor & Audit Plan: Audits will be conducted by Admissions or designee.
Audits will be conducted on a monthly basis for 4 months starting 4/13/2026.
• Sustainability Plan: Quality Management meetings will be held monthly for the next 4 months. Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

65d - Initial Direct Care Training

2. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct Care Staff Person A, hired on [redacted] began providing unsupervised ADL services on [redacted]. However, the staff did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

• Immediate Resolution: Employee was removed from floor immediately completed the direct care training. Facility audited DCS to ensure accurate and timely completion of Direct Care Training. Training completed by 4/17/2026

• Training: New hires will be required to complete Direct Care Staff Course and Competency test before unsupervised ADL services can be provided. Current DCS to be trained by 4/17/2026.

• Monitor & Audit Plan: Audits will be conducted by HR or designee.
Audits will be conducted on a monthly basis for 4 months starting 4/13/2026.

65d - Initial Direct Care Training (continued)

• Sustainability Plan: Quality Management meetings will be held monthly for the next 4 months. Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator.
See attached.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

65e - 12 Hours Annual Training

3. 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

Direct Care Staff Members B and C did not receive 12 hours of annual training related to job duties for the 2025 training year.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

Immediate Resolution: 2025 previous year training acknowledgement signed by staff member C, 12-hour training completed 3/16/2026, employee B no longer works at facility.
• Training: The facility has implemented an annual training program for all staff that includes Required regulatory topics (e.g., resident rights, infection control, fire safety, medication assistance).
• Monitor & Audit Plan: ED or designee will Conduct monthly audits of training hours completed for 4 months starting 4/13/2026

• Sustainability Plan: Quality Management meetings will be held monthly for the next 4 months and topics will be reviewed and updated.
Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator. Ongoing education
See attached.

Proposed Overall Completion Date: 04/17/2026

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

65g - Annual Training Content

4. 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.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

65g Annual Training Content *(continued)*

Description of Violation

Staff Person B & C did not receive annual training in Fire safety, Emergency preparedness procedures, Resident rights, Older Adult Protective Services Act (OAPSA), Falls and Prevention during training year 2025.

Plan of Correction ***Directed ([redacted] - 04/16/2026)***

• Immediate Resolution: Unable to correct previous year training.

• Training: Documentation of completed training has been placed in a binder alphabetically. The facility has implemented a standardized annual training program for all staff
• Monitor & Audit Plan: ED or designee will Conduct monthly audits of training hours completed for 4 months starting 4/13/2026
• Sustainability Plan: Quality Management meetings will be held monthly for the next 4 months and topics will be reviewed and updated. Quality Management meeting minutes will be maintained in a folder by the Personal Care Administrator.

Proposed Overall Completion Date: 04/17/2026

Directed: In addition to the above plan of correction, Staff Person C will complete training in Resident Rights, OAPSA, and Fall Prevention. These training will be applied to the 2025 training year and be done in addition to any training requirements for the 2026 training year.

Directed Completion Date: *04/27/2026*

Implemented ([redacted] - 05/28/2026)

85e - Trash Outside Home

5. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 9:28 a.m., the lid of the dumpster was opened allowing for access of insects and rodents to the garbage in the dumpster.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

Immediate Resolution:
The dumpster lid was closed immediately upon discovery
Staff were instructed to ensure the lid remains closed after each use.

Training: staff will be re educated by 4/17/2026 on proper waste disposal procedures, including keeping dumpster lids closed at all times when not in use.

Monitor & Audit Plan: Audits will be conducted by Maintenance or designee.
Audits will be conducted on a monthly basis for 4 months starting 4/13/2026.

• Sustainability Plan: Sustainability Plan: Quality Management meetings will be held monthly for the next 4 months and topics will be reviewed and updated. Quality Management meeting minutes will be maintained in a binder by

85e - Trash Outside Home (continued)

the Personal Care Administrator.
See attached.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

86b - Bathroom

6. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

At 9:20 a.m. the hallway C1 bathroom near room 100 had an exhaust fan that was inoperable and the bathroom had no window or other source of ventilation.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

Immediate Resolution: The exhaust fan was assessed immediately upon discovery.
Maintenance was notified, and repairs were completed and scheduled promptly on March 19,2026.
inspection of fan by an outside agency showed fan to be working filters cleaned and inspected

Training: A preventive maintenance schedule has been implemented and updated to include routine checks of all exhaust fans and ventilation systems. Staff will be instructed to report any ventilation issues immediately to maintenance.

• Monitor & Audit Plan: maintenance staff will be assigned responsibility for conducting and auditing these checks on a monthly basis for 4 months starting 4/13/2026

• Sustainability Plan: Quality Management meetings will be held monthly for the next 4 months and topics will be reviewed and updated. Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator.
See attached.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

92 - Windows

7. Requirements

2600.
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

At 9:37 a.m., 10 window screens on operable windows located on the back of the facility were tattered and torn. The tears measured up to 10 inches long.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

• Immediate Resolution:

92 Windows (continued)

Upon identification of the deficiency, the facility conducted a full inspection of all windows. Removed severely damaged screens, Measured screen dimensions for replacement Repair (re screen) or replace damaged screens all will be completed by 4/17/2026

• Training: Maintenance staff and direct care staff were re educated on: Identification of damaged or improperly secured screens and Proper procedures for submitting maintenance requests

• Monitor & Audit Plan: The Maintenance/Designee will complete monthly audits for 4 months starting 4/13/2026 inspecting all windows and screens.

• Sustainability Plan: Quality Management meetings will be held monthly for the next 4 months and topics will be reviewed and updated. Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator.

See attached.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

102f - Towel/Washcloth/Soap

8. Requirements

2600.
102.f. An individual towel, washcloth and soap shall be provided for each resident.

Description of Violation

A used bar of soap was found in the spa shower on the 2nd floor. The soap was not labeled with a resident's name.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

• Immediate Resolution: The unlabeled bar of soap in the 2nd floor spa shower was removed and discarded immediately upon discovery.

• Training: All direct care and housekeeping staff were re educated on: The requirement that each resident must have individually assigned soap The prohibition of shared or unlabeled personal hygiene items Infection control practices related to cross contamination prevention Staff were instructed to: Remove and report any unlabeled items immediately Ensure resident items are properly labeled and stored separately by 4/17/2026

• Monitor & Audit Plan: The RWD/Designee will conduct: Monthly documented audits for 4 months starting 4/13/2026 of all shared bathing areas, including the 2nd floor spa shower.

• Sustainability Plan: Quality Management meetings will be held monthly for the next 4 months and topics will be reviewed and updated. Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator.

See attached.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

103b - Clean/Sanitized Kitchen Surfaces

9. Requirements

2600.

103b - Clean/Sanitized Kitchen Surfaces *(continued)*

103.b. Kitchen surfaces must be of a nonporous material and cleaned and sanitized after each meal.

Description of Violation

On 3/12/26 at 2:12 p.m., the oven grill was not in use and was not cleaned after the last use. There was a layer of leftover food debris along the surface space in front of the grill.

Plan of Correction ***Accept (- 04/16/2026)***

• Immediate Resolution: The oven grill and surrounding surface area were cleaned and sanitized immediately upon discovery. All visible food debris and residue were removed, and the area was restored to a sanitary condition.
• training: Dietary staff were re-educated on Proper cleaning and sanitation procedures for all kitchen equipment The requirement to clean equipment immediately after each use, regardless of frequency of use Daily and weekly cleaning expectations, education completed by 4/17/2026.
• Monitor & Audit Plan: The facility has implemented a routine cleaning schedule for all kitchen equipment, including infrequently used items such as the oven grill. Cleaning responsibilities have been clearly assigned to dietary staff per shift. Dietary manager/designee will conduct Monthly audits for 4 months starting 4/13/2026 of all equipment
• Sustainability Plan: Quality Management meetings will be held monthly for the next 4 months and topics will be reviewed and updated. Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented (- 05/28/2026)

103i - Outdated Food

10. Requirements

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

Description of Violation

On 3/12/26 at 2:15 p.m., there were 8 thickened cranberry cocktail cups that had expired on 11/6/25.

Repeat Violation: 3/18/25.

Plan of Correction ***Accept (- 04/16/2026)***

• Immediate Resolution: The eight expired thickened cranberry cocktail cups were removed and discarded immediately upon discovery on 3/12/26. A full inspection of all nourishment rooms, kitchen storage areas, and medication/dietary supply areas was conducted to identify and remove any additional expired items.
• Training: Dietary staff and direct care staff were re-educated by 4/17/2026 on: The importance of checking expiration dates prior to use and during storage Proper food storage and rotation practices (FIFO) The requirement to immediately discard expired items
• Monitor & Audit Plan: The Designee or Dietary Supervisor will audit for 4 months starting 4/13/2026 checks of all food, beverages, and thickened liquids for expiration dates
• Sustainability Plan: Quality Management meetings will be held monthly for the next 4 months and topics will be reviewed and updated. Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator.

Licensee's Proposed Overall Completion Date: *04/17/2026*

103i Outdated Food *(continued)*

Implemented ([redacted] - 05/28/2026)

121a Unobstructed Egress

11. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At 9:39 a.m., there was a combination lock on the courtyard gate that blocked egress from the courtyard.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

• Immediate Resolution: The combination lock was removed immediately A facility-wide inspection of all exit doors and gates was conducted to ensure no other exits were obstructed or improperly secured.
• Training: All staff were re-educated on the requirement that all exits must remain accessible and unobstructed at all times, this education will be completed by 4/17/2026.
• Monitor & Audit Plan: maintenance /designee will audit all exit access points for 4 months starting 4/13/2026 Any issues identified will be corrected immediately and documented.
• Sustainability Plan: Quality Management meetings will be held monthly for the next 4 months and topics will be reviewed and updated. Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator.
See attached.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

132c Fire Drill Records

12. Requirements

2600.
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 home 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 fire drill record for the drill conducted on 1/25/25 indicates 35 residents were in the home and 48 residents were evacuated, on 8/30/25, the record indicates 42 residents in the home and 54 evacuated, on 9/25/25, the record indicates 40 residents in the home and 51 residents evacuated, on 10/25/25, the record indicates 43 residents in the home and 44 residents evacuated, and on 11/18/25, the record indicates 44 residents in the home and 47 were evacuated.

Repeat Violation: 4/29/25.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

• Immediate Resolution: Incorrect fire drill documentation was unable to correct entries
staff responsible for completing the drills were re-educated immediately on proper documentation requirements. A current fire drill was conducted and accurately documented

132c - Fire Drill Records (continued)

• Training: All staff responsible for fire drills including supervisors and designated fire drill leaders will receive training on Accurate fire drill documentation. Proper accounting of all residents, staff, and visitors during drills. completing fire drill logs in real time to prevent errors. This training will be completed by 4/17/2026.
• Monitor & Audit Plan: • The Maintenance director or designee will: Review 100% of fire drill documentation immediately after each drill for accuracy and completeness Conduct monthly audits for 4 months starting 4/13/2026 of fire drill records Accurate census count at time of drill Accurate evacuation count and Consistency between counts

• Sustainability Plan: Fire drill documentation accuracy will be incorporated into the facility's: Quality Management meetings and Safety committee meetings Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator.
See attached.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

132d - Evacuation

13. Requirements

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

Description of Violation

The home's maximum safe evacuation time specified in writing by a fire safety expert is 8 minutes and 35 seconds. The home exceeded that evacuation time during the following drills: 3/7/25 – evacuation time 9 minutes 22 seconds, 4/27/25 – evacuation time 9 minutes 28 seconds, 6/19/25 – evacuation time 9 minutes 14 seconds, 8/30/25 – evacuation time 9 minutes and 22 seconds, and 9/30/25 - evacuation time 8 minutes 54 seconds.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

• Immediate Resolution: Staff were re-instructed on evacuation responsibilities, including: Use of nearest exits Furniture, equipment, and pathways were checked to ensure all exits and evacuation routes were unobstructed. Maintenance verified that all exit doors function properly and open easily.
• Training: All staff will receive in-service training on: Evacuation procedures and response expectations Time-sensitive evacuation requirements (8 minutes 45 seconds) Staff roles during drills and real emergencies Proper use of all available exits (not just main entrances) Techniques for assisting residents with mobility limitations efficiently and safely
• Monitor & Audit Plan: • The Maintenance director/designee will: Monitor all fire drills for evacuation time compliance Conduct monthly fire drills on all shifts each drill will include Timed evacuation documented Reviewed immediately after completion Any drill exceeding the required time will trigger: Immediate re-training A repeat drill within a short timeframe audit for 4 months starting 4/13/2026
This training will be completed by 4/17/2026
• Sustainability Plan: Evacuation performance will be incorporated into the facility's: Quality Management meetings and Safety committee meetings Quality Management meeting minutes will be maintained in a binder by the

132d Evacuation (continued)

Personal Care Administrator.

See attached.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented (- 05/28/2026)

141b1 - Annual Medical Evaluation

14. Requirements

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

Description of Violation

Resident 6's most recent medical evaluation was completed on The resident's medical evaluation was not dated by the physician, and the physician did not indicate if the residents' needs could be met in the personal care home setting.

Repeat Violation: 8/19/25.

Plan of Correction ***Accept (- 04/16/2026)***

• Immediate Resolution: physician was contacted immediately, and evaluation was corrected and fully completed with the Physician signature, date and Documentation confirming whether the resident's needs can be met in the personal care home
• Training: staff responsible for medical evaluation will receive training on: Requirements for annual medical evaluations Required components of the evaluation, including Physician signature and date Statement confirming appropriateness for personal care home placement this training will be completed by 4/17/2026
• Monitor & Audit Plan: RWD or designee will audit for 4 months starting 4/13/2026 all annual medical evaluations with due dates and annual review checklist to ensure all required elements are complete
• Sustainability Plan: Compliance with medical evaluation requirements will be incorporated into the facility's: Quality Management meetings and Safety committee meetings Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented (- 05/28/2026)

144c1 - Smoking Area Guidelines

15. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

Description of Violation

At 9:34 a.m., upwards of 50 cigarette butts were discarded in the mulch near the cement patio.

Repeat Violation: 3/18/25, 4/19/25, and 6/25/25.

144c1 Smoking Area Guidelines *(continued)*

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

•Immediate Resolution: All cigarette butts were removed immediately from the mulch area upon discovery. the affected area was cleaned and inspected to ensure no remaining debris or fire hazards.
•Training: All staff will receive in service training on Fire safety risks associated with improper cigarette disposal Monitoring of resident smoking practices Ensuring residents use designated smoking areas and proper receptacles Maintain clearly designated smoking areas with proper receptacles
•Monitor & Audit Plan: Maintenance Director or designee will: Conduct daily inspections of the smoking area(s)Ensure receptacles are emptied regularly and maintained in safe condition audits of outdoor areas for cleanliness and safety for 4 months starting 4/13/2026 Any concerns will be addressed immediately and documented.
•Sustainability Plan: Smoking safety will be incorporated into the facility's: Quality Management meetings and Safety committee meetings Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator. Staff training will be completed by 4/17/2026.

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

181c - Self-administration Assessment

16. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

On 3/12/26 at 3:14 p.m., Resident #1 had a tube of Triamcinolone Acetonide Cream 0.025% stored in their room that they self administer. The resident has not been assessed to self administer medications or have medications at bedside.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

• Immediate Resolution: The medication (Triamcinolone Acetonide Cream 0.025%) was removed from the resident's room immediately and secured per facility medication storage policy.
• Training: All staff responsible for medication management will receive training by 4/17/2026. The necessity of a documented assessment by a qualified practitioner prior to allowing self administration Proper storage of medications
• Updating support plans to reflect medication status
• Monitor & Audit Plan: • RWD or designee will Audit bi weekly room checks to ensure no unauthorized medications are present for 4 months starting 4/13/2026
• Sustainability Plan: Self administration Assessment will be incorporated into the facility's: Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

183e - Storing Medications

17. Requirements

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

Description of Violation

On 3/12/26 resident #2's Pregabalin 50 mg medication card was tampered with and had tape on the back of the card holding capsule #16 in place.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

• Immediate Resolution: the tampered Pregabalin medication card was removed from use immediately. A replacement medication card was obtained from the pharmacy. The medication count was verified and documented to ensure accuracy.
• Training: All staff responsible for medication administration will receive training on: Proper storage of medications Prohibition of altering or tampering with medication packaging (including use of tape or other materials) Procedures for handling damaged or compromised medication cards
• Monitor & Audit Plan: The RWD or designee will implement monthly medication cart audits to ensure proper storage and packaging integrity for 4 months starting 4/13/2026. training will be completed by 4/17/2026.
• Sustainability Plan: - Storing Medications will be incorporated into the facility's: Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

185a - Implement Storage Procedures

18. Requirements

2600.
185.a. The home 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

On 3/12/26, Resident #3's PRN medications Loperamide 2mg cap, Docus Sod S/G 100mg and Atropine Sulfate 1% were not available in the home to be administered if needed.
On 3/12/26, the home could not provide the daily blood glucose readings for Resident #1 and Resident #2's Free Style Libre 2.

Repeat Violation: 3/18/25.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

• Immediate Resolution: The missing PRN medications were ordered and obtained immediately from the pharmacy.
• Training: All direct care and medication administration staff will be re-educated on Medication reordering procedures by 4/17/2026.
• Monitor & Audit Plan: The RWD or designee will do bi-weekly audits x 3 months on Glucose Monitoring and to be sure the readings are retrievable, all ordered medications are on-site and PRN medications are available at all

185a - Implement Storage Procedures (continued)

times. training will be completed by 4/17/2026.
• Sustainability Plan: Implement Storage Procedures will be incorporated into the facility's: Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

187d - Follow Prescriber's Orders

19. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #4 is prescribed Metoprolol twice daily, with special instructions to hold medication if systolic blood pressure is less than 90 or pulse is less than 60. On 2/16/26, the resident's pulse at 8:00a.m. was 58, on 2/22/26 at 8:00a.m. their pulse was 55, on 3/1/26 at 8:00p.m. their pulse was 54, on 3/2/26 at 8:00p.m. their pulse was 56, and on 3/3/26 at 8:00p.m their pulse was 55, and on 2/20/26 the residents blood pressure was 83/52 at 8:00a.m. During all indicated dates and times, the medication was administered and not held as ordered by the prescriber.
Resident #4 has an order for a warm eye compress two times per day to be administered at 10:00a.m. and 8:00p.m. On 2/17/26, the resident received this medication/treatment at 11:27a.m. and on 3/3/26, the medication/treatment was applied at 11:08am.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

Immediate Resolution: Staff re-educated to hold medications per prescriber orders based on vital signs. staff reminded of scheduled treatment times.
Training: Med-Tech's will have training on specific instructions, including conditional administration based on vital signs. Proper documentation and MAR accuracy. Administration of treatments/medications at prescribed times. Importance of holding or delaying medication/treatment per prescriber orders.
Monitor & Audit Plan: RWD or designee will perform audits of MARs and treatment logs bi-weekly x 30 days to ensure: Medications are held when indicated by vital signs and Treatments are administered within scheduled times. training will be completed by 4/17/2026
• Sustainability Plan: - Follow Prescriber's Orders will be incorporated into the facility's: Quality Management meeting minutes will be maintained in a binder by the Personal Care Administrator

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 06/02/2026)

190c - Record of Training

20. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

190c Record of Training *(continued)*

Description of Violation

Staff person C's annual medication administration practicum training record dated 2/5/25 and 8/13/25 by the trainer does not include staff person C's signature.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

• Immediate Resolution: Training records for all staff were reviewed to ensure signatures and any missing signatures were corrected
• Training: Staff will be educated on the importance of signing training records to verify Participation in training and Successful completion; this will be completed by 4/17/2026.
• Monitor & Audit Plan: the RWD or designee will review training records for 4 months starting 4/13/2026 to ensure: Staff signatures are present on all completed trainings as of 4/10/2026. Documentation includes trainer name, date, and source of training this was completed by 4/10/2026. Staff will be educated by 4/17/2026.
• Sustainability Plan: Record of Training will be incorporated into the facility's: Quality Management meeting and minutes will be maintained in a binder by the Personal Care Administrator

Proposed Overall Completion Date: 04/17/2026

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)

225c - Additional Assessment

21. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #6's was admitted to hospice on [redacted] The home did not complete the significant change assessment until [redacted].

Repeat Violation: 1/9/26.

Plan of Correction ***Accept ([redacted] - 04/16/2026)***

1. Immediate Resolution
Resident #6's significant change in condition (hospice admission on [redacted]) was identified. A significant change assessment was completed on [redacted]. The assessment has now been reviewed for accuracy and completeness. The delay in completion was addressed with responsible staff.

• The Resident Care Director (RCD) or designee will be responsible for initiating assessments immediately upon notification of a significant change.
3. Staff Training
• All clinical staff will have training completed by 4/17/2026 to
o Identification of "significant change in condition"
o Timelines and documentation expectations
4. Monitoring and Auditing

225c - Additional Assessment (continued)

• The RCD or designee will audit:
o Monthly for 4 months to ensure assessments are completed timely.
o Hospice admissions
o Hospital returns
o Notable declines in condition
• Findings will be documented and reviewed with administration.

_____

5. Sustainability Plan
• Sustainability Plan: Assessment will be incorporated into the facility's: Quality Management meeting and minutes will be maintained in a binder by the Personal Care Administrator

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented (- 05/28/2026)

252 - Record Content

22. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

Resident #5's record does not include identifying marks, hair color, eye color, gender, or race. Resident 7's record does not include identifying marks.

Plan of Correction ***Accept (- 04/16/2026)***

Immediate Resolution
• Resident #5's record was reviewed and updated to include all required demographic information: race, gender, height, weight, hair color, eye color, religious affiliation (if applicable), and identifying marks.
• Resident #7's record was reviewed and updated to include identifying marks.
• All updates have been verified for accuracy and completeness.
• The Resident Care Director (RCD) or designee will review all new admissions within 24 hours to ensure records are complete.
3. Staff Training
• All staff responsible for admissions and recordkeeping will be trained on:
o Required demographic elements and proper documentation
• Training will be completed by 4/17/2026
4. Monitoring and Auditing
• The RCD or designee will conduct:
o audit of all current resident records to ensure all required information is present.
o Weekly audits of new admissions for 4 Months
• Any deficiencies identified will be corrected immediately and staff will be re-educated as needed.
• Sustainability Plan: Assessment will be incorporated into the facility's: Quality Management meeting and minutes will be maintained in a binder by the Personal Care Administrator

252 - Record Content (continued)

Licensee's Proposed Overall Completion Date: *04/17/2026*

Implemented ([redacted] - 05/28/2026)