pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **EC OPCO LAKEMONT FARMS LLC**
LEGAL ENTITY

To operate **CELEBRATION VILLA OF LAKEMONT FARMS**
NAME OF FACILITY OR AGENCY

Located at **3275 WASHINGTON PIKE, BRIDGEVILLE, PA 15017**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **140**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 30**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **March 19, 2026** until **September 19, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **450812**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MAY 15, 2026

[redacted]
EC OPCO Lakemont Farms LLC
[redacted]

RE: Celebration Villa of Lakemont Farms
3275 Washington Pike
Bridgeville, Pennsylvania 15017
License/COC #: 450812

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on December 15, 2025, December 16, 2025, and March 6, 2026, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from MARCH 19, 2026 to SEPTEMBER 19, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
42(b)	II	82	$5	$410	5 calendar days from mailing date of this letter
101(j)(7)	III	82	$3	$246	15 calendar days from mailing date of this letter
185(a)	III	82	$3	$246	15 calendar days from mailing date of this letter
187(a)	III	82	$3	$246	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected and full compliance with the regulation has been achieved by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675
[redacted]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *CELEBRATION VILLA OF LAKEMONT FARMS* **License #**: *45081* **License Expiration**: *03/19/2026*

Address: *3275 WASHINGTON PIKE, BRIDGEVILLE, PA 15017*

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

Administrator

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

Legal Entity

Name: *EC OPCO LAKEMONT FARMS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *03/17/1999* **Issued By**: *PA Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *110* **Waking Staff**: *83*

Inspection Information

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

Reason: *Renewal, Provisional, Incident* **Exit Conference Date**: *01/16/2026*

Inspection Dates and Department Representative

12/15/2025 On Site: [redacted]

12/16/2025 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *140* **Residents Served**: *69*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Lower level - MC* **Capacity**: *30* **Residents Served**: *27*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *69*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *41* **Have Physical Disability**: *0*

Inspections / Reviews

12/15/2025 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *02/21/2026*

02/23/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/11/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/02/2026*

02/27/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/11/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/11/2026*

04/13/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/11/2026*

Reviewer: [redacted] **Follow Up Type:** *Exception*

3c Post Current License

1. Requirements

2600.
3.c. The personal care home 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 personal care home.

Description of Violation

The licensing inspection summary (LIS) dated [redacted] was not posted in a public and conspicuous place. It was not included in the "DHS inspections" binder at the front desk.

Plan of Correction ***Accept [redacted] - 02/27/2026)***

ACTION:? On 12/16/2025 a copy of the licensing inspection summary (LIS) dated 8/21/25 was printed and placed in the "DHS Inspections " binder at the front desk, by the Executive Director.
TRAINING:? On 2/17/2025 the Administrative Assistant was educated on regulation 2600.3c by the Executive Director.
ONGOING: Effective 12/17/2025, a copy of all new licensing inspection summary (LIS) reports will be printed immediately once received and placed in the "DHS Inspections" binder at the front desk, by Executive Director. Effective 12/17/25 a weekly audit x 4, and then monthly x 4 by the Executive Director to ensure a copy of the licensing inspection summary (LIS) is posted in a public and conspicuous place, in the "DHS inspections binder" at the front desk. Documentation of monitoring/audits will be kept.

Licensee's Proposed Overall Completion Date: *02/27/2026* Not Implemented [redacted] - 04/13/2026)

17 Record Confidentiality

2. 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 [redacted] at approximately 9:10 a.m., the staff and resident privacy coding document was attached to the licensing Inspection summary dated [redacted] that was posted in the "DHS inspections" binder at the front desk of the home and included the names of numerous residents to include: residents [redacted] and [redacted]

On [redacted] at 11:17 a.m., there was an unattended closet labeled "CATV" room with bifold doors by room [redacted]. The lock on the door was not engaged.
There were stacked boxes with one box containing manilla envelopes with confidential records for the following residents:
Resident [redacted]
- *MA51 medical form including diagnoses*
- *Invoice and check written with account number*
- *Non-payment of rent letter*
- *Letter from payer that [redacted] is out of money*
- *POLST – unsigned*
- *Dementia assessment*

17 - Record Confidentiality (continued)

Resident [redacted]

• letter from an attorney requesting medical records for resident regarding an incident and injury. the letter from attorney included the resident's name, DOB, SSN

• Preadmission screening

• Medical evaluation completed [redacted]

• Service Plan

Plan of Correction ***Accept ([redacted] - 02/23/2026)***

ACTION: On 12/15/2025 all confidential resident materials were immediately removed from the closet and placed into the locked files room, by the Executive Director. On 12/15/2025 the resident privacy code attached to the licensing summary was removed by the inspector.

TRAINING: On 12/17/2025, the Executive Director and Director of Nursing were educated on regulation 2600.17, by the Regional Director of Operations. By 3/3/2026 all staff will be educated on regulation 2600.17 by the Executive Director. Documentation shall be kept in accordance with Regulation 2600.65i.

ONGOING: Effective 12/22/2025 the Executive Director has completed rounds twice weekly for the past month, then monthly x4, throughout to ensure that all confidential material is appropriately stored and document findings. Then the Executive Director/Resident Care Coordinator will perform monthly audits.

Licensee's Proposed Overall Completion Date: *03/03/2026* Not Implemented [redacted] - 04/13/2026)

18 - Compliance With Laws

3. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act – Enactment Act of June 23, 2016 indicates in Section 3.(b)(3): The battery shall be labeled with the date of installation and replaced at least once annually or at such time as the unit signals a drained or failing battery. However, on [redacted] *at approximately 12:10 p.m., the batteries in the carbon monoxide (CO) detector outside of the sprinkler system/boiler room (room* [redacted] *were not dated. Only "1/22" was written in permanent marker on the CO detector casing.*

Plan of Correction ***Accept [redacted] - 02/23/2026)***

ACTION:? The Director of Maintenance provided the inspector with the logging of the batteries being changed on 1/22/2025 along with the monthly testing that is conducted to ensure that the batteries are functioning. The Director of Maintenance replaced and placed the date on the battery itself on 12/15/2025.

TRAINING: On 12/17/2025, the Executive Director provided training to the Director of Maintenance and Assistant Maintenance Tech on regulation 2600.18. Documentation shall be kept in accordance with Regulation 2600.65i.

ONGOING: Effective 1/15/2026, the Maintenance Director will review monthly during carbon monoxide testing to ensure that the carbon monoxide detector is dated and batteries replaced within 1 year.

Licensee's Proposed Overall Completion Date: *02/21/2026* Not Implemented [redacted] - 04/13/2026)

42b - Abuse

4. Requirements

2600.

42b Abuse *(continued)*

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] at approximately 2:00 p.m., staff person A heard yelling coming from resident [redacted] room on the home's secure dementia care unit. When staff person A entered the room, resident [redacted] was lying on [redacted] right side on the floor in front of the dresser. Framed photographs from [redacted] dresser had been knocked to the floor. Resident [redacted] was behind the entry door in the closet. Resident [redacted] said [redacted] pushed me. [redacted] pushed me." indicating that resident [redacted] had pushed [redacted] Resident [redacted] was complaining of pain in [redacted] right hip and right knee. According to Staff person B, Director of Nursing, just after the incident, resident [redacted] reported to [redacted] that resident [redacted] was going through resident [redacted]s drawers and when resident [redacted] got up to get resident [redacted] out of [redacted] room, resident [redacted] pushed resident [redacted] causing [redacted] to fall. EMS was called and resident [redacted] was taken to the hospital where [redacted] was diagnosed with a comminuted fracture of the right femoral neck requiring right hip intramedullary nailing and follow up rehabilitation at a nursing facility. As of [redacted] resident [redacted] was still at the nursing facility.

Repeat Violation [redacted]

Plan of Correction ***Directed ([redacted] - 02/27/2026)***

ACTION: On 12/9/2025, resident [redacted] was redirected out of the room. On 1/21/2026, a 30 day notice was served to resident [redacted] Administrative staff are actively assisting family with alternate placement.
TRAINING:? On 12/17/2025 the management team, which included the Director of Nursing, Resident Care Coordinator, Director of Maintenance, Memory Care Coordinator, Administrative Assistant, Dietary Director and Life Enrichment Coordinator, were educated on regulation 2600.42.b by the Executive Director, on 2/10/2026 training for all direct care staff began and will be completed by 3/3/2026 on regulation 2600.42b by the Executive Director. All staff members will be trained on The Older Adult Protective Services Act by 3/10/2026 by the Executive Director. Documentation of the staff training shall be kept in accordance with 2600.65i.
ONGOING: The PCP is actively following the resident [redacted] for medication management. Staff are monitoring the resident and redirecting [redacted] to structured activities within [redacted] room and another room set up just for this purpose such as organizing belongings, folding clothing, and making or remaking the bed to safely accommodate [redacted] need to rummage and stay occupied. Direct Care Staff, Memory Care Coordinator and Assistant Director of Nursing will monitor resident [redacted]s body language for signs and symptoms of anger, agitation, irritation, and aggression, and will make attempts to de escalate, redirect as needed. Private interviews of three residents per week for three months and three residents per month thereafter by the Executive Director to ensure compliance with Regulation 2600.42.b. These interviews will begin 3/2/2026.

Proposed Overall Completion Date: 03/10/2026

DIRECTED
Within 5 days or receipt of the plan of correction: The administrator shall develop and implement a process to identify and document resident aggressive behaviors. This process shall include identifying positive interventions specific to the residents to protect any alleged aggressor or potential victim based on the circumstances. Documentation of the implementation of this process shall be kept. [redacted] 2/27/26

Not Implemented [redacted] - 04/13/2026)

Directed Completion Date: *03/10/2026*

82a - Poisonous Materials

5. Requirements

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

Description of Violation

On [redacted] at 11:40 a.m., there was an uncovered grey wash basin with loose powdered laundry detergent in it in the cupboard above the washer in the 2nd floor laundry. The laundry detergent was not stored in its original container with manufacturer label.

Plan of Correction ***Accept [redacted] - 02/27/2026)***

ACTION: The Maintenance Director labeled the detergent on 12/16/2025.
TRAINING: On 12/17/2025 the Maintenance Director along with the rest of the management team, which included the Director of Nursing, Resident Care Coordinator, Memory Care Coordinator, Administrative Assistant, Dietary Director and Life Enrichment Coordinator, were trained by the Executive Director on regulation 82.a.
ONGOING: The Maintenance Director will comply with regulation 82.a, Effective 12/17/25, an audit of all laundry rooms will be conducted weekly x4, then monthly x 4, by the Maintenance Director to ensure all poisonous materials shall be stored in their original, labeled containers. Documentation of monitoring/audits will be kept.

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

Implemented [redacted] - 04/13/2026)

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

On [redacted] at approximately 11:30 a.m., there was an approximately nickel-sized piece of feces stuck on the front of the outside of the toilet bowl in the bathroom of resident room #240.

On [redacted] at approximately 11:30 a.m., there was no hand towel nor means to dry hands in the bathroom of room [redacted]

On [redacted] at 11:32 a.m., there was a buildup of black crud in the sink drain in the kitchenette by room [redacted]

Plan of Correction ***Accept [redacted] - 02/27/2026)***

ACTION: On August 21, 2025, the day of the inspection, the housekeeping staff cleaned the nickel-sized piece of feces on the toilet bowl of room [redacted], added a supply of hand towels and cleaned the sink drain of kitchenette by room [redacted]
TRAINING: The Executive Director will complete training on regulation 2600.85.a with the Maintenance Director, Maintenance Assistant, Housekeeping staff and direct care team training by March 3, 2026. Documentation of the staff training shall be kept in accordance with regulation 2600.65i.
ONGOING: Effective 3/3/2026 weekly x4, monthly x4 audit will be completed by the Executive Director, to ensure that sanitary conditions are being met, that residents' bathrooms have towels or means to dry hands, kitchenettes remain free of black crud build up, and toilets remain free of feces. Documentation of monitoring /audits will be kept.

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

Implemented ([redacted] - 04/13/2026)

91 - Telephone Numbers

7. Requirements

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

Description of Violation

On [redacted] at approximately 11:30 a.m., there were no emergency phone numbers to include the nearest hospital and fire department on or by either of the two landline telephones in resident room [redacted]

On [redacted] at approximately 12:35 p.m., there were no emergency phone numbers to include the nearest hospital and fire department on or by the landline telephone in the wellness room.

Repeat Violation [redacted] et al.

Plan of Correction ***Accept [redacted] - 02/23/2026)***

ACTION: Immediately after inspection on 12/16/2025, the administrator posted the emergency numbers in room [redacted]. The emergency numbers were already posted in the wellness office, on the desk, next to the landline.
TRAINING: On December 17, 2025 Administrative team which included the Director of Maintenance, Director of Culinary, Director of Maintenance, Director of Life Engagement, Director of Nursing, Administrative Assistant and the Memory Care Coordinator, received training on regulation 2600.91 completed by the Executive Director. Documentation of the staff training shall be kept in accordance with 2600.65i.
ONGOING: The home's management staff which includes the Executive Director, Maintenance Director, Memory Care Coordinator, Director of Culinary, Assistant Director of Nursing and the Resident Care Coordinator began room audits on 12/22/2025. These audits included but were not limited to ensuring emergency telephone numbers are in place. These audits were conducted a minimum of 3 times weekly over the last 6 weeks to ensure continued compliance with regulation 2600.91. A record of these audits is kept in the administrator's office.

Licensee's Proposed Overall Completion Date: *02/21/2026* Not Implemented [redacted] - 04/13/2026)

100b - Removal Snow/Obstructions

8. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On [redacted] at 11:10 a.m., there was an approximately ½" accumulation of snow covering the sidewalk outside of the stairwell exit near Room [redacted] leading to the front of building.

On [redacted] at 11:50 a.m., there was an approximately ½ - ¾ inch accumulation of snow covering the sidewalk outside of the stairwell exit by room [redacted] leading to the employee parking lot.

On [redacted] at 11:55 a.m., there was an approximately 1 ½" accumulation of snow covering the patio and along the egress route to the opening in the fence outside of the double glass exit doors leading from the first floor library.

On [redacted] at 12:14 p.m., there was snow ranging from 1" to approximately 4" covering the sidewalks of the exit

100b - Removal Snow/Obstructions (continued)

path to the gate of the Memory Care courtyard.

Plan of Correction ***Accept [redacted] - 02/23/2026)***

ACTION:
It was actively snowing at the time of inspection with heavy snowfall the night before. Immediately after the Maintenance Director completed the community walk-through with the inspector, [redacted] assisted the Maintenance Assistant in clearing the accumulating snow from the areas identified and then checked all other exits and sidewalks.
TRAINING: On December 17, 2025 both the Maintenance Director and Maintenance Assistant received training on regulation 2600.100b completed by the Executive Director. Documentation of the staff training shall be kept in accordance with 2600.65i.
ONGOING: If the snowfall happens quickly in the future and one of the two Maintenance team members are not available to actively clear walkways the members of maintenance will communicate need for further support from other staff persons to assist in shoveling and salting said areas. Additionally, the maintenance staff will monitor all exits and sidewalks during inclement weather. In the event neither are on site the manager on duty will take on this responsibility.

Licensee's Proposed Overall Completion Date: *02/21/2026*

Implemented [redacted] - 04/13/2026)

101j7 - Lighting/Operable Lamp

9. 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

On [redacted] at 12:22 p.m., there was no operable lamp or other source of lighting that could be turned on at bedside in room [redacted].

On [redacted] at 12:30 p.m., the bedside lamp on the night table for the bed on the bathroom side of resident room [redacted] was approximately three feet away from the bed and there was a dining type chair between the bed and the night table. The lamp could not be reached from bedside.

Repeat Violation [redacted] et al.

Plan of Correction ***Accept ([redacted] - 02/23/2026)***

ACTION: The chair in room [redacted] was moved, along with the nightstand and lamp. A touch lamp has since been ordered and installed as resident in [redacted] moves items around. Resident in room [redacted] has a working lamp, within reach of [redacted] recliner chair where [redacted] sleeps per [redacted] request.
TRAINING: On December 17, 2025 Administrative team which included the Director of Maintenance, Director of Dietary, Director of Maintenance, Director of Life Engagement, Director of Nursing, Administrative Assistant and the Memory Care Coordinator received training on regulation 2600.101j7. Direct Care staff and housekeeping staff will be trained by 3/3/2026 on regulation 2600.101j7. Documentation of the staff training shall be kept in accordance with 2600.65i.
ONGOING: The home's management staff, which includes the Executive Director, Maintenance Director, Memory Care Coordinator, Dietary Director, Assistant Director of Nursing and the Resident Care Coordinator, began room

101j7 - Lighting/Operable Lamp (continued)

audits on 12/22/2025. These audits included but were not limited to ensuring that working lamps within reach of residents beds that are in place. These audits were conducted a minimum of 3 times weekly over the last 6 weeks to ensure continued compliance with regulation 2600.101j7. A record of these audits is kept in the administrator's office.

Licensee's Proposed Overall Completion Date: *03/03/2026* Not Implemented [redacted] - 04/13/2026)

121a - Unobstructed Egress

10. 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

On [redacted] at 12:15 p.m., the gate to exit the courtyard outside of the memory care unit was unable to be opened after the posted code was entered into the key pad. The gate was frozen shut.

Plan of Correction ***Accept [redacted] - 02/27/2026)***

ACTION:? On 12/16/2025 the Director of Maintenance was able to open the gate to exit the courtyard of the memory care.
TRAINING:? On 12/17/2025 the Director of Maintenance and Maintenance Assistant were trained on regulation 2600.121.a by the Executive Director. Documentation of the training shall be kept in accordance with regulation 2600.65.i.
ONGOING: Effective 12/16/25, during periods of prolonged extreme cold, the Director of Maintenance will apply a light silicone spray to the magnetic lock's external mechanism to help prevent freezing. The mechanism will be inspected daily by Director of Maintenance or the Manager on Duty, to ensure the egress routes from the building are unlocked and unobstructed. Documentation of monitoring /audits will be kept.

Licensee's Proposed Overall Completion Date: *02/27/2026* Not Implemented [redacted] 04/13/2026)

132c - Fire Drill Records

11. 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 following fire drills do not include the amount of time to evacuate in minutes and seconds:
- [redacted], *evacuation time was 13 minutes*
- [redacted] *evacuation time was 15 minutes*

Repeat Violation [redacted] et al.

Plan of Correction ***Accept [redacted] 02/23/2026)***

ACTION:? Zero seconds were added to the evacuation times by the Executive Director on 12/17/2025.
TRAINING:? On 12/17/2025 the Executive Director and the Maintenance Director were trained by the Regional Director of Operations on regulation 132.c to clarify that when there are zero seconds it must be added to the documentation. Documentation of the training shall be kept in accordance with regulation 2600.65.i.

132c Fire Drill Records (continued)

ONGOING: The Executive Director and Regional Director of Operations will review drill documentation monthly for 6 months; the review will be initialed by each to document the review.

Licensee's Proposed Overall Completion Date: *02/21/2026* Not Implemented [redacted] - 04/13/2026)

141a - Medical Evaluation

12. Requirements

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

Description of Violation

Resident [redacted]s initial medical evaluation dated [redacted] does not indicate if the resident's needs can be safely met at the personal care home.

Plan of Correction ***Accept ([redacted] 02/27/2026)***

ACTION:?On 12/17/2025 resident [redacted]s initial medial evaluation dated was updated to reflect the resident's needs can be safely met at the personal care home, by the Executive Director. On 1/20/26 an audit of all current residents' medical evaluation was completed by Regional Director of Clinical Services to ensure all resident medical evaluations are accurate, complete, and timely. Documentation of this audit will be kept in the administrator's office.
TRAINING:? On 12/17/2025 the Director of Nursing and Resident Care Coordinator was educated on regulation 2600.141a by the Executive Director.
ONGOING : Effective 12/17/2025 all new medical evaluations will be reviewed to ensure the resident's needs can be safely met at the personal care home, prior to placing in the residents file, weekly x 4 weeks, then monthly x 4 by the Executive Director, Director of Nursing, Assistant Director of Nursing, Resident Care Coordinator or designee.

Licensee's Proposed Overall Completion Date: *02/27/2026* Not Implemented [redacted] 04/13/2026)

183d - Prescription Current

13. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted] at 1:25 p.m., there was a blister pack with pharmacy label for resident [redacted] of [redacted] (gen for [redacted]) Take 1 and ½ tablets by mouth every 8 hours as needed for congestion/cough for 3 days. The medication was dispensed on 10/10/25 but was still in the Memory Care medication cart.

On [redacted], resident [redacted] was ordered [redacted] immediate release tablet Take 1 tablet ([redacted] total) by mouth every 4 (four) hours as needed for moderate pain (pain scale 4 7) for up to 7 days. On [redacted] at 10:15 a.m., there was a bottle of this medication with one tablet remaining in the medication cart.

Repeat Violation [redacted] et al.

183d - Prescription Current *(continued)*

Plan of Correction ***Accept [redacted] - 02/23/2026)***

ACTION:? On 12/16/2025 the medications were removed from the cart by the Resident Care Coordinator.
TRAINING:? On 12/17/2025 the Director of nursing and Resident Care Coordinator were educated on regulation 2600.183d by the Executive Director, on 2/10/2026 training for all Certified Med Techs began and will be completed by 3/3/2026 on regulation 2600.183d by the Executive Director. Documentation of the staff training shall be kept in accordance with 2600.65i.
ONGOING: Cart audits began on 12/22/2025 and have been conducted weekly. Since the inspection date, audits have been conducted to include, but are not limited to, the removal of medications that are no longer ordered by the Director of Nursing, Assistant Director of Nursing, Resident Care Coordinator or appointed Certified Med Tech audits will be documented and kept in the Director of Nursing Office.

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

Implemented [redacted] - 04/13/2026)

183e - Storing Medications

14. 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

Resident [redacted] is ordered [redacted] – use 2 sprays in each nostril daily. The box for this bottle of medication had a sticker on it that indicated an open date of [redacted] According to the manufacturer (Apotex) directions, the bottle should be discarded after 120 actuations which should have occurred by approximately [redacted]

Plan of Correction ***Accept [redacted] - 02/23/2026)***

ACTION:? On 12/16/2025 a new bottle of [redacted] was ordered by the Resident Care Coordinator and placed on the cart.
TRAINING:? On 12/17/2025 the Director of Nursing and Resident Care Coordinator were educated on regulation 2600.183e by the Executive Director, on 2/10/2026 training for all Certified Med Techs began and will be completed by 3/3/2026 on regulation 2600.183e by the Executive Director. Documentation of the staff training shall be kept in accordance with 2600.65i.
ONGOING: Effective 12/22/2025, during weekly med cart audits all medications will be reviewed to ensure open dates, align with the manufacturer's instructions by the Director of Nursing, Assistant Director of Nursing, Resident Care Coordinator, or appointed Certified Med Tech audits will be documented and kept in the Director of Nursing office.

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

Implemented [redacted] - 04/13/2026)

185a - Implement Storage Procedures

15. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

On [redacted] resident [redacted] was ordered [redacted] immediate release tablet – Take 1 tablet (5 mg total) by mouth every 4 (four) hours as needed for moderate pain (pain scale 4-7) for up to 7 days. On [redacted] at 10:15 a.m., there was a bottle of this medication filled on [redacted] with a quantity of 5 tablets that had one tablet remaining. Although the computer count indicated only 1 tablet should remain, the home only had documentation that one tablet was administered on [redacted]. Administration was not documented on any other medication administration records (MARs) from [redacted] through [redacted] The home could not account for the other three tablets.

Resident [redacted] is ordered [redacted] - inject 1 injection intramuscularly every 15 minutes until BGM greater than 70 as needed if BGM<70 and patient symptomatic and unable to swallow. If BGM<70 and symptoms resolved, administer glucose gel as order. On [redacted] at 11:30 a.m., this medication was not available in the home.

Repeat Violation [redacted] et al., [redacted]

Plan of Correction ***Accept [redacted] 02/23/2026)***

ACTION:?On 12/22/25 a complete med cart audit was completed by the Director of Nursing and Resident Care Coordinator to ensure all medications were available for distribution.
TRAINING:? On 12/17/2025 the Director of Nursing and the Resident Care Coordinator were educated on regulation 2600. 185a, by the Executive Director. On 2/10/2026 training for med trained staff was started and will be completed by 3/3/2026 on regulation 2600. 185a, by the Executive Director.
ONGOING: Cart audits began on 12/22/2025 and have been conducted weekly. Since the inspection date, audits have been conducted to include, but are not limited to, the removal of medications that are no longer ordered, all ordered medications are available, all medications are reconciled, and verify that all remaining quantities match the current medication administration records and prescribed amounts by the Director of Nursing, Resident Care Coordinator or appointed Certified Med Tech audits will be documented and kept in the Director of Nursing Office.

Licensee's Proposed Overall Completion Date: *03/03/2026* Not Implemented [redacted] - 04/13/2026)

186c - Change in Medications

16. Requirements

2600.
186.c. Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by nurses in accordance with regulations of the Department of State. The resident's medication record shall be updated as soon as the home receives written notice of the change.

186c - Change in Medications *(continued)*

Description of Violation

On [redacted] Resident [redacted] was ordered [redacted] – Insert [redacted] into the [redacted] 2 (two) times a week by a [redacted]. However, the home requested that the house doctor discontinue this medication on [redacted] because it was not available when the home audited the medication cart.

As of [redacted] resident [redacted] was ordered peri care by a [redacted] that included - Wash only with CeraVe gentle cleanser or water at least daily, rinse thoroughly. Pat dry. Topical Vaseline at least twice daily. However, on [redacted], the home requested that the house doctor discontinue these medications because they were not available in the home.

Plan of Correction ***Accept [redacted] - 02/27/2026)***

ACTION:? The Resident Care Coordinator received an order from the PCP to discontinue orders for estradiol 10mcg tablets and CeraVe gentle cleanser once daily, along with topical Vaseline twice daily.
On 12/17/2025 the Director of Nursing clarified these discontinued orders with Dr. Lavelle.

TRAINING:? On 2/20/206 the Resident Care Coordinator was educated on regulation 2600.186.c by the Executive Director.
ONGOING: All requests to discontinue orders will be directed to the prescribing physician, or in case of an emergency and alternate prescriber will be notified.

Licensee's Proposed Overall Completion Date: *02/27/2026* Not Implemented [redacted] 04/13/2026)

187a - Medication Record

17. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident [redacted] is ordered [redacted] - take 1 tablet by mouth every 6 hours as needed for cough. The only entry on the resident's December 2025 medication administration record (MAR) indicates [redacted] –take 1 tablet by mouth three times daily.

Resident [redacted] is ordered [redacted] injectable solution – For glucose less than 70 initiate [redacted] protocol; for glucose 70-130 give 0 units of insulin; for glucose 130-180 give 2 units of insulin; for glucose 181-240 give 4 units of insulin; for glucose 241-300 give 6 units of insulin; for glucose 301-350 give 8 units of insulin; for glucose 351-400 give 10 units of insulin; for glucose greater than 400 give 12 units of insulin and call the medical doctor on call. However, on the following dates/times, the amount of insulin administered was not entered on the resident's December 2025 medication administration record (MAR); only the blood glucose (BG) reading was entered:

[redacted]

Repeat Violation [redacted] et al.

Plan of Correction ***Accept [redacted] - 02/27/2026)***

ACTION:?The December MAR's order reads "[redacted] tablet take 1 tablet by mouth 3 times daily" The

187a - Medication Record (continued)

record indicates that the medication ordered was administered per order dated 10/15/2025. The Director of Nursing provided a counseling and education to the staff member responsible for not completing correct documentation. On 2/20/2026 an audit of all residents who receive sliding scale insulin to ensure there is a place to document the amount of insulin administered was conducted by Director of Nursing and Assistant Director of Nursing.
Training: On 12/17/2025, the Director of Nursing and Resident Care Coordinator was provided with training on regulation 2600. 187a, by the Executive Director. Starting on 2/10/2026 training for all Certified Med Techs began and will be completed by 3/3/2026 on regulation 2600.187.a by the Executive Director. Documentation of the staff training shall be kept in accordance with 2600.65i.
ONGOING: Effective 12/22/2025 the Director of Nursing, Assistant Director of Nursing, and Resident Care Coordinator will review all orders to ensure the orders have been transcribed on to the MAR and include supplementary documentation to reflect the amount of insulin given.

Licensee's Proposed Overall Completion Date: *03/03/2026* Not Implemented [redacted] - 04/13/2026)

225c - Additional Assessment

19. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

The annual assessment completed on [redacted] for resident [redacted] admitted [redacted] does not include the following diagnoses as indicated on the resident's most recent medical evaluation completed [redacted] major depressive disorder and age-related nuclear cataract.

The annual assessment completed on [redacted] for resident [redacted] admitted [redacted], does not include numerous diagnoses as indicted on the resident's most recent medical evaluation dated [redacted] to include: [redacted] and [redacted]

Plan of Correction

Accept ([redacted] - 02/23/2026)

ACTION: On 12/15/2025 resident [redacted] assessment was updated to include diagnosis of [redacted] and age-related nuclear cataract, by the Executive Director. On 12/15/2025 resident # 10's assessment was updated to include diagnosis of [redacted] and [redacted] by The Executive Director. An audit of all current residents assessments was completed between 12/17/2025 and 1/22/2026 to ensure all diagnosis indicated are included on the residents most recent medical evaluation, by the Executive Director and the Resident Care Coordinator.
TRAINING: On 12/17/2025 the Director of Nursing and Resident Care Coordinator were educated on regulation 2600.225c, by the Executive Director.
ONGOING: Effective 1/29/2026 the Director of Nursing and/or the Assistant Director of Nursing will monitor completion and accuracy of assessments by reviewing 4 assessments a week x4, then 4 monthly x 4. Documentation to be kept and reviewed at monthly Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: *02/21/2026* Not Implemented [redacted] - 04/13/2026)

231e - No Objection Statement

20. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

There is no documentation that Resident [redacted] and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit (SDCU).

There is no documentation that resident [redacted] and the resident's designated person have not objected to the resident's admission or transfer to the SDCU.

Plan of Correction ***Accept [redacted] - 02/23/2026)***

ACTION:? On 12/15/2025 the Executive Director had resident [redacted] sign [redacted] consent to be in the secured dementia care unit and given to inspector on site, resident [redacted] was out of the community and has since discharged. All charts were audited by the Executive Director on 12/16/2025 to ensure all other SDCU residents' consents were completed.
TRAINING: On 12/17/2025 the Director of Nursing, Resident Care Coordinator and the Administrative Assistant were trained on regulation 231.e by the Executive Director. Documentation of this training shall be kept in the Executive Director's office in accordance with regulation 2600.65.i.
ONGOING: The Executive Director will audit all new admission files to ensure that the consent is completed in a timely manner and in the resident's chart. Documentation of this audit will be kept and reviewed at the home's next Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *02/21/2026* Not Implemented [redacted] - 04/13/2026)

254a - Records Discharge/Active

22. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On [redacted] at 9:10a.m., there was an unlocked, unattended office with door wide open that contained shelves of resident records to include records for residents [redacted] and [redacted]

Plan of Correction ***Accept [redacted] - 02/23/2026)***

ACTION: On 12/15/2025 the door of the unattended office that contained shelves of resident records to include for residents [redacted] and [redacted] was closed and locked by the Executive Director.
TRAINING: On 12/17/2025 the Executive Director, Director of Nursing, and Assistant Director of Nursing were educated on regulation 2600.254.a, by Regional Director of Operations. By 3/3/2026 all staff will be educated on regulation 2600.254.a by the Executive Director. Documentation of this training will be kept in accordance with Regulation 2600.65i.
ONGOING: Effective 12/22/2025 the Executive Director will complete rounds twice weekly rounds for one month, then monthly x4, throughout to ensure that all confidential material is appropriately stored and document findings. Then Executive Director/Resident Care Coordinator will perform monthly audits. Documentation of these audits will be kept in the administrator's office.

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

Implemented [redacted] - 04/13/2026)

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

Facility Information

Name: *CELEBRATION VILLA OF LAKEMONT FARMS* **License #**: *45081* **License Expiration**: *03/19/2026*

Address: *3275 WASHINGTON PIKE, BRIDGEVILLE, PA 15017*

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

Administrator

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

Legal Entity

Name: *EC OPCO LAKEMONT FARMS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *03/17/1999* **Issued By**: *PA Dept of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *104* **Waking Staff**: *78*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *03/06/2026*

Inspection Dates and Department Representative

03/06/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *140* **Residents Served**: *82*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Lower Level* **Capacity**: *30* **Residents Served**: *28*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *82*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *50*

Have Physical Disability: *1*

Inspections / Reviews

03/06/2026 - Partial

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *03/26/2026*

Inspections / Reviews *(continued)*

03/31/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/05/2026*

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

04/13/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/05/2026*

Reviewer: [redacted] **Follow Up Type:** *Exception*

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] at approximately 6:00 p.m., on the first-floor memory care unit resident [redacted] assaulted resident [redacted] biting [redacted] on [redacted] right shoulder penetrating the skin, causing it to bleed, and leaving four red puncture marks. Direct care staff persons C, E, and F, attempted to deescalate and separate resident [redacted] from continuing [redacted] assault of resident [redacted] at which time resident [redacted] then attempted to bite direct care staff person C's hand. Direct care staff person's E and F eventually were able to gain control of resident [redacted] and guide [redacted] down the hallway away from resident [redacted] Resident [redacted]s wounds were cleaned with soap and water. A follow-up appointment was conducted virtually with [redacted] POA and physician. An oral antibiotic and a topical cream were prescribed for resident [redacted] Direct care staff will closely monitor resident [redacted]s care needs to eliminate potential for future adverse behaviors.

On [redacted] at approximately 8:53 p.m., on the first-floor memory care unit direct care staff person A placed resident [redacted] into [redacted] apartment [redacted] and got [redacted] ready to go to bed for the night. As direct care staff person A attempted to leave the apartment resident [redacted] attempted to exit the apartment behind [redacted] however, direct care staff person A forcibly held the door closed, preventing resident [redacted] from leaving the apartment. As resident [redacted] frantically attempted to open the door [redacted] started screaming for help and to be let out of the apartment while direct care staff person A continued to forcibly hold the door shut. Direct care staff persons B and C went into the hallway and witnessed direct care staff person A forcibly holding the door closed to apartment [redacted]. Direct care staff persons B and C immediately demanded that direct care staff person A release the door and to let resident [redacted] out of the apartment. When direct care staff person A was confronted by the other staff members [redacted] turned and walked down the hallway. Resident [redacted] exited the apartment and direct care staff person C attended to the resident.

Repeat Violation [redacted]

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

ACTION: Immediately, residents [redacted] and [redacted] were separated by the staff. On February 26, 2026, resident [redacted] was provided with a 30-day notice by the Executive Director. On 2/23/2026 staff intervened and opened the resident's door. On 2/23/2026, direct Care Staff person A was sent home and suspended pending investigation, by the Executive Director.
TRAINING On 3/18/2026, a representative from the Ombudman's office trained staff on Resident's Rights that included regulation 2600.42.b. Documentation of this training shall be kept in the Executive Director's office in accordance with regulation 2600.65.i.
ONGOING Effective 3/24/2026, the administrator will conduct 3 residents' interviews weekly for 3 months, and then 3 residents a month thereafter to ensure compliance with regulation 2600.42.b. Documentation of these interviews shall be kept in the Executive Director's office. Results to be reviewed at the next monthly Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *03/26/2026* Not Implemented [redacted] - 04/13/2026)

88a Surfaces

2. Requirements

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

88a Surfaces *(continued)*

Description of Violation

On [redacted] at approximately 9:26 a.m., the green and white colored 12" inch x 12" inch square vinyl composition tile flooring at the bottom of the AL3 stairwell in front of the ground floor emergency exit door had a large section of tile floor approximately 4' feet wide by 7' feet long of dried mud coating the tiles from muddy rain water that had come in from the outside side walk and underneath the metal emergency door.

On [redacted] at approximately 9:40 a.m., on the top landing and the first two steps of AL1 stairwell there were what appeared to be multiple clumps of white cotton strands from the inside of pull up briefs or incontinent pads laying on the green and white vinyl composition tile.

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

ACTION On 3/6/2026, both areas were cleaned by the Director of Maintenance.
TRAINING On 3/7/2026, the Director of Maintenance was in serviced on regulation 2600.88.a by the Executive Director. Documentation of this training shall be kept in the Executive Director's office in accordance with regulation 2600.65.i.
ONGOING Effective 3/8/2026, the Maintenance Director will complete rounds twice weekly rounds for one month, then monthly x4, throughout to ensure that all stairwells are clean and free of any debris. Documentation of these audits will be kept in the executive director's office. Results to be reviewed at the next monthly Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *03/26/2026* Not Implemented [redacted] - 04/13/2026)

202 - Prohibitions

3. Requirements

2600.
202. The following procedures are prohibited:
1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).

Description of Violation

On [redacted] at approximately 8:53 p.m., on the first floor memory care unit direct care staff person A did confine resident [redacted] involuntarily by forcibly holding the door of apartment [redacted] closed, preventing resident [redacted] from leaving the apartment. This resulted in resident [redacted] to frantically start to pull on the door attempting to exit the apartment and causing [redacted] to scream for help and to be let out of the apartment while direct care staff person A continued to forcibly hold the door shut.

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

ACTION On 2/23/2026 staff intervened and opened the resident's door. Direct Care Staff member # A was suspended pending investigation, by the Executive Director.
TRAINING On 3/18/2026, a representative from the Ombudman's office trained staff on Resident's Rights that included regulation 2600.202. Documentation of this training shall be kept in the Executive Director's office in accordance with regulation 2600.65.i.
ONGOING Effective 3/24/2026, the administrator will conduct 3 residents' interviews weekly for 3 months, and

202 Prohibitions (continued)

then 3 residents a month thereafter to ensure compliance with regulation 2600.202. Documentation of these interviews shall be kept in the Executive Director's office. Results to be reviewed at the next monthly Quality Assurance meeting.

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

Implemented (- 04/13/2026)

233c - Key-Locking Devices

4. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On at approximately 09:30 a.m., the directions for operating the home's locking mechanism were not conspicuously posted near the two sets of emergency double doors in the first floor memory care that led to the outside patio areas.

Plan of Correction ***Accept - 03/31/2026)***

ACTION: On 3/6/2026 the codes were placed on the keypad for exit, by the Marketing Director.
TRAINING On 3/7/2026, the Director of Maintenance, Director of Memory Care, Director of Nursing and the Resident Care Coordinator were all in serviced on regulation 2600.233c by the Executive Director.
ONGOING: Effective 3/7/2026, the Executive Director or Director of Maintenance will audit twice weekly for 1 month and monthly thereafter x3 months to ensure that exit codes are posted. Documentation of the audits shall be kept in the Executive Director's office. Results to be reviewed at the next monthly Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: *03/26/2026* Not Implemented - 04/13/2026)