pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC**
LEGAL ENTITY

To operate **SPRING MILL SENIOR LIVING**
NAME OF FACILITY OR AGENCY

Located at **3000 BALFOUR CIRCLE PHOENIXVILLE, PA 19460**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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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 **98**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 22**

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 **May 5,** **2026** until **May 5,** **2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **146320**

ISSUING OFFICER

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 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: July 27, 2026

[redacted]
KAPG Phoenixville Senior Housing OPCO, LLC
[redacted]
[redacted]

RE: Spring Mill Senior Living
3000 Balfour Circle
Phoenixville, Pennsylvania 19460
License #: 146320

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on March 9, 10, and 11, 2026 and May 18 and 19, 2026, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

July 20, 2026

[redacted]
KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC
[redacted]

RE: SPRING MILL SENIOR LIVING
3000 BALFOUR CIRCLE
PHOENIXVILLE, PA, 19460
LICENSE/COC#: 14632

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/09/2026, 03/10/2026, 03/11/2026 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: *SPRING MILL SENIOR LIVING* **License #**: *14632* **License Expiration**: *05/05/2026*

Address: *3000 BALFOUR CIRCLE, PHOENIXVILLE, PA 19460*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *09/10/2009* **Issued By**: *East Pikeland Township*

Type: *I-2* **Date**: *09/10/2009* **Issued By**: *East Pikeland Township*

Type: *Other* **Date**: *09/10/2009* **Issued By**: *East Pikeland Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *106* **Waking Staff**: *80*

Inspection Information

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

Reason: *Renewal, Provisional, Incident* **Exit Conference Date**: *03/11/2026*

Inspection Dates and Department Representative

03/09/2026 - On-Site: [redacted]

03/10/2026 - On-Site: [redacted]

03/11/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care Unit* **Capacity**: *22* **Residents Served**: *18*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*

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

Have Mobility Need: *34* **Have Physical Disability**: *0*

Inspections / Reviews

03/09/2026 Full

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

04/16/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/13/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/13/2026*

07/20/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/13/2026*

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

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

On [redacted], the home's current violation report, dated [redacted], was not posted in a conspicuous and public place in the home.

Repeat Violation: [redacted] et. al.

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

• 3/9/26: Executive Director posted the home's current violation report from 11/20/25 in the conspicuous and public binder located to the left of the front desk.
• 3/26/2026: Executive Director reeducated the Management Team to this regulation.
• 3/31/2026: Executive Director replaced the?11/20/25 LIS with the LIS report from 2/18/26, 2/19/26.
• 4/3/2026: Executive Director replaced the 2/18/26, 2/19/26 LIS report with the home's current violation report from the 3/9/26,3/10/26, 3/11/26 LIS.

• 4/9/2026: Binder Cover holding the home's current violation report and a copy of Chapter 2600. Personal Care Homes was labeled: "Contents of this binder include Spring Mill Senior Living's current license inspection summary report. A copy of Chapter 2600, the regulations governing Personal Care Homes.
• 4/10/26: Email verification that the home's current violation report is posted will be sent from the front desk, Lead Concierges, or designee to the Executive Director 1 x a week x 4 weeks, then 1 x a month for 2 months

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented[redacted] - 07/20/2026)

5a1 - DHS Access

2. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On [redacted], during the entrance conference which started at 9:12 AM, the Department requested access to staff scheduling records. Staff person A, the Interim Executive Director/Administrator was not able to access verifiable staffing records until [redacted] where the schedules were recreated by hand using timecards and agency staff billing reports.

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

• 3/26/2026: Executive Director reeducated the Management Team to this regulation.
• 4/10/2026: Regional Clinical Specialist trained Health Care Coordinator/Scheduler to maintain schedule accurately in OnShift an online scheduling tool.
• 4/13/2026: Executive Director or designee will audit OnShift against daily attendance to ensure the online tool is maintained accurately and can easily be printed and the home is able to provide immediate access to the home's records to the Agents of the Department 1 x a week for 4 weeks, then 1 x a month for 2 months. POC audits will be

5a1 - DHS Access (continued)

reviewed during monthly Quality Assurance Meeting for 2 months.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

16c - Written Incident Report

3. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident [redacted] moved into the home on [redacted]. The following medications prescribed to resident [redacted] but were not administered because the medications were not available in the home;

[redacted] - Take one tablet by mouth daily was not administered between [redacted] to [redacted]; [redacted] - Take 1 tablet by mouth twice a day was not administered between [redacted] to [redacted] and missed again on [redacted]; [redacted] - Take 1 tablet by mouth twice daily was not administered at 8:00 am on [redacted], and [redacted] and at 8:00 pm on [redacted] and [redacted]

The home did not report these incidents to the Department.

Repeat Violation: [redacted].

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

• 2/3/2026: Resident [redacted] was discharged from community.

• 3/9/2026: Executive Director submitted the Incident Report Form to the Department to identify this reportable incident.

• 3/25/2026: Facility selected a new pharmacy provider that provides additional services geared towards assisting with previous survey deficiencies included performing the monthly medication cycle fill.

• 4/10/2026: The Med Check In Report will be audited by the DHW or designee weekly x 4 weeks, then monthly x 2 months. POC audits will be reviewed during monthly Quality Assurance meetings

• 4/22/2026: Executive Director or designee will initiate ongoing reeducation & reminders for all medication administration staff to ensure they understand the reporting requirements if unable to obtain a medication

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

17 - Record Confidentiality

4. 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 9:35 AM, assignment sheets for resident care including including incontinence issues

17 - Record Confidentiality (continued)

and behaviors were unlocked, unattended, and accessible in a bin labeled "Assignment Sheets" outside of the memory care Director's office.

Repeat Violation: [redacted], et. al.

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

• 3/9/2026: The mailbox, staff were utilizing to return daily assignments sheets at the end of each shift, was removed from the outside of the Memory Care Directors office door.
• 4/1/2026: The community eliminated paper daily assignment sheets and now utilize electronic tools to guide staff with daily tasks.
• 4/22/2026: Record Confidentiality will be a topic in-serviced during monthly Town Halls for the next 3 months.
• 4/22/2026: Facility POC Audit Tool will be used to monitor compliance weekly x 4 weeks, monthly x 2 months, results reviewed during monthly QA meeting.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

28e - Death of a Resident

5. Requirements

2600.
28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident [redacted] passed away on [redacted]. Resident [redacted]s personal belongings were removed from the room on [redacted]; however, a refund for the amount of the difference between any payments made and the cost of elder care provided to the resident prior to their passing was not issued until [redacted]

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

• 3/26/2026: Executive Director reeducated the Management Team to this regulation.
• 4/10/2026: Refund tracker added to the Manager Meeting Agenda and reviewed during all manager meetings. The Executive Director will escalate pending refunds that are not in process by day 20 to ensure all refunds are provided within 30 days.
• 4/10/2026: Morning Meeting minutes are retained in an online workbook and serve as the audit tool and results will be reviewed during monthly QA meetings.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

28f - Resident's Funds and 30-day Refund

6. Requirements

2600.

28f - Resident's Funds and 30-day Refund *(continued)*

28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident [redacted] was informed verbally on [redacted] that they could not return to the home. The resident's room was fully cleared on [redacted]. As of [redacted], the home has not provided the required refund.

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

• 3/26/2026: Executive Director reeducated the Management Team to this regulation.

• 4/10/2026: Refund tracker added to the Manager Meeting Agenda and reviewed during all manager meetings. The Executive Director will escalate pending refunds that are not in process by day 20 to ensure all refunds are provided within?30 days.

• 4/10/2026: Morning Meeting minutes are retained in an online workbook and serve as the audit tool and results will be reviewed during monthly QA meetings.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

42b - Abuse

7. 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

Resident [redacted] date of admission was [redacted]. According to the resident's progress notes on [redacted], "Resident sent out 911 to Phoenixville Hospital for further evaluation regarding missed dose of [redacted] and [redacted]" Resident [redacted] was sent to the hospital again on [redacted] and was not allowed to return to the home. The resident's November 2025 and December 2025 Medication Administration Records (MARs) show the resident missed multiple medications between late November and throughout December while on premises. The home failed to properly administer the resident's medications to maintain the resident's physical health.

Repeat Violation: [redacted].

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

• 2/3/2026: Resident [redacted] was discharged from community.

• 3/25/2026: Facility selected a new pharmacy provider that provides additional services geared towards assisting with previous survey deficiencies included performing the monthly medication cycle fill.

• 4/10/2026: The Med Check In Report will be audited by the DHW or designee weekly x 4 weeks, then monthly x 2 months. POC audits will be reviewed during monthly Quality Assurance meetings.

• 4/14/2026: Regional Nurse or will initiate ongoing reeducation & reminders for all medication administration staff to ensure they understand the reporting requirements if unable to obtain a medication and that failure to obtain and provide a resident their medication could be considered a resident right violation.

• 4/22/2026: Executive Director or designee will initiate ongoing reeducation & reminders for all medication administration staff to ensure they understand the reporting requirements if unable to obtain a medication and that failure to obtain and provide a resident their medication could be considered a resident right violation.

Licensee's Proposed Overall Completion Date: *05/13/2026*

42b Abuse *(continued)*

Implemented [redacted] - 07/20/2026)

51 Criminal Background Check

8. Requirements

2600.
51. Criminal History Checks Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101 10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A's date of hire was 01/14/26, staff person A's criminal background check request was not completed. The Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) requires the home to determine if the applicant has held permanent residency in a state other than Pennsylvania within the past two years and request the appropriate criminal background checks from the Pennsylvania State Police and FBI on or before the first day of work.

Repeat Violation:[redacted].

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

• 3/10/2026: Facility obtained Staff Person A's appropriate criminal background check from Pennsylvania State Police.
• 3/10/2026: The facility will obtain the required criminal background checks from the Pennsylvania State Police and FBI on or before the first day of work for any interim, temporary workers.
• 3/26/26: Executive Director reeducated the management team to this regulation.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented ([redacted] - 07/20/2026)

60a Staff/Support Plan

9. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

During an interview on [redacted] a resident stated that their morning medications are late every other day because there is only one medication technician (medtech) on their floor. The medtech starts on one side of the floor one day and by the time the medtech gets to the resident, the morning medications are considered late. The next day, the medtech will start on the opposite end of the floor and then keep rotating. Based on this interview it appears that the medication administration services could not be provided due to lack of appropriately trained direct care staffing available in the home.

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

• 4/13/2026: Facility will evaluate and implement assigned start times for each assigned med cart.
• 4/14/26: Regional nurses will educate medication administration staff to the assigned start times for each hallway to ensure residents receive their medication in the same timeframe each day.
• 4/10/2026: All new admission medication pass times will be assessed to ensure they are the correct time for the designated hallway. New admissions medication pass times will be audited 1 x a week for 4 weeks, then 1x a month x 2 months. Results will be reviewed during the monthly QA meeting.

60a - Staff/Support Plan *(continued)*

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

65a - FS Orientation 1st Day

10. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms until [redacted]. Staff person B has not received training on telephone use and notification of emergency services.

Interviews with agency staff indicate they are required to complete the orientation paperwork but not complete the actual training in general fire safety and emergency preparedness.

Repeat Violation: [redacted].

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

• 4/14/2026: The community's Fire Safety Trainor will train HCC's to conduct a general orientation in fire safety and emergency preparedness including all requirements in 65.a.

1. Evacuation procedures.

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

5. The location and use of fire extinguishers.

6. Smoke detectors and fire alarms.

7. Telephone use and notification of emergency services.

• 4/15/2026: The names of any ancillary staff member(s) in the community who received the training will be documented on the HCC 24-hour report. Training will be sent to Executive Director via the daily scanned HCC report and added to Ancillary Staff Fire Safety Binder

65a - FS Orientation 1st Day (continued)

• 4/15/2026: Binder will be audited during monthly QA meetings x 2 months

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

65b - Rights/Abuse 40 Hours

11. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B completed their 40th scheduled work hour on [redacted]. However, this staff person did not complete training on resident rights until [redacted] Staff person B has not completed training in the following topics: emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), and reporting of reportable incidents and conditions.

Staff person C completed their 40th scheduled work hour in December 2025. However, this staff person did not complete training in the reporting of reportable incidents and conditions.

Staff person D completed their 40th scheduled work hour in September 2025. However, this staff person did not complete training in the reporting of reportable incidents and conditions.

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

• 8/27/25: Staff member D completed Reportable Incidents and Conditions on first day of hire.
• 12/20/25: Staff member C completed Reportable Incidents and Conditions on first day of hire.
• 3/29/2026: Staff member B was a temporary ancillary staff member, last day worked was 3/9/26.
• 3/26/26 – 4/22/2026: All employees were enrolled in mandatory Relias Abuse Training: Abuse Neglect, and Exploitation and Abuse: Preventing, Recognizing, and Reporting
• 4/20/26: Audits of 10% of new hire orientation documentation will be conducted weekly x 4 weeks then monthly x 2 months. Audits will be reviewed during monthly QA meetings.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] 07/20/2026)

65f - Training Topics

12. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

65f - Training Topics *(continued)*

3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person E did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2025.

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

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

• 2/27/26: Staff person E is on maternity leave and will be retrained on [redacted] *first day back to work (date unknown at this time) on preadmission screening form, assessment tools, medical evaluation and support plan.*
• 4/10/2026: Preadmission screening form, assessment tool, medical evaluation and support plan training was added to Spring Mill Orientation Day 1.
• 4/14/2026 - 4/30/2026: Executive Director or designee All direct care staff employees will receive training on assessment tools, medical evaluation and support plan training.
• 4/20/26: Audits of 10% of new hire orientation documentation will be conducted weekly x 4 weeks then monthly x 2 months. Audit will be reviewed during monthly QA meetings

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] ***- 07/20/2026)***

82c - Locking Poisonous Materials

13. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Old Spice Alpine with Hemp Seed Oil Deodorant, with a manufacture's label indicating "Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in room [redacted]*, which is in the memory care unit. Not all the residents of the home, including the residents of the memory care unit, have been assessed capable of recognizing and using poisons safely.*

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

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

• 3/9/2026 The Old Spice Alpine and Hemp Seed Oil Deodorant were removed from room [redacted] *during survey in the presence of the department representative.*
• 3/24/2026: Facility Director and Interim Memory Care Director conducted two separate audits to confirm there were no poisonous materials unlocked, unattended or accessible to any residents in memory care.
• 3/13/2026: Facility Director replaced under-cabinet door locks with combination locks to ensure both physical and visual safety checks are completed.

82c - Locking Poisonous Materials (continued)

• 3/17/2026: Memory Care Director or designee will audit memory care rooms and common areas 3 x a week x 4 weeks. Then 1 x a week for 4 weeks, then 1 time a month for 2 months. POC audits will be reviewed during monthly QA meetings.

• 4/14/26: New Staff Orientation agenda will include "Spring Mill Safety Training In-Service".

• 4/22/26: Town Hall agenda will include "Spring Mill Safety Training In-Service" and will repeat x 3 months.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] 07/20/2026)

85a - Sanitary Conditions

14. Requirements

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

Description of Violation

On [redacted], at approximately 4:49 PM, resident [redacted] glucometer had a reading of [redacted] This was not documented on resident [redacted]s medication administration record. Resident [redacted]s glucometer was used for resident [redacted] This was verified by checking both resident's glucometers against the documented readings on the respective resident Medications Administration Records (MARs). The [redacted] reading did not appear on resident [redacted] MAR at 4:49 PM on [redacted] however it was listed on resident [redacted]s MAR at that time and date.

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

• 3/9/2026: Facility replaced all glucometers with new glucometers for each resident.

• 4/14/26: Regional nurse to train medication administration staff trained on not sharing resident glucometers.

• 4/19/26: HCC or designee will conduct glucometer audits weekly x 4 weeks, then monthly x 2 months to ensure all residents have their own glucometer. Results will be reviewed during monthly QA meetings

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

15. Requirements

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

Description of Violation

On [redacted], at approximately 9:22 AM, the toilet seat for the bathroom in room [redacted] was laying in the shower. A toilet seat riser was over the toilet, however the rim of the toilet bowl was stained with urine.

On [redacted] at approximately 9:25 AM, a towel was hanging on a hook in the shared bathroom in room [redacted] Neither the towel or the hook were labeled.

On [redacted], at approximately 9:47 AM, an unlabeled washcloth and an unlabeled loofah were observed in the second floor spa bathroom.

On [redacted] between 9:29 AM and 9:54 AM, staff person F was observed administering 10 different medications to one resident and getting blood pressure readings from two additional residents on two different floors. Staff person F did not wash or sanitize their hands or wear gloves before administering medications or taking the blood pressure readings. Also, the equipment for the blood pressure readings was not sanitized between residents.

85a Sanitary Conditions *(continued)*

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

• 3/9/2026: Room [redacted] rim of the toilet bowl was cleaned. Room [redacted] labeling was updated in shared bathroom. 2nd Floor Spa unlabeled washcloth and loofah were discarded, and spa was deep cleaned. Staff member F is no longer an employee.

• 3/26/26: Executive Director reeducated management team to this regulation.

• 4/22/2026: Executive Director, designee will in service staff to this regulation during Town Hall. Town Hall reeducation will continue x 3 months.

• 4/30/2026: Facility Audit Tool will be used 3 x a week x 4 weeks; 1 x a week for 4 weeks; 1 x a month for 1 month. Audits will be reviewed during monthly QA meetings

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented ([redacted] 07/20/2026)

85d - Trash Receptacles

16. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [redacted] at approximately 9:47 AM, there was a half full, uncovered, unattended trash can in the second floor spa bathroom. The trash can was partially filled with used briefs and feces was smeared on the inside of the can.

Repeat Violation: [redacted]

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

• 3/9/2026: Facility replaced the trash can in the 2nd floor spa room.

• 3/26/2026: Executive Director reeducated management team to this regulation.

• 4/22/2026: Executive Director, designee will in service staff to this regulation during Town Hall. Town Hall reeducation will continue x 3 months.

• 4/30/2026: Facility Audit Tool will be used 3 x a week x 4 weeks; 1 x a week for 4 weeks; 1 x a month for 1 month. Audits will be reviewed during monthly QA meetings.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] 07/20/2026)

87 - Lighting

17. Requirements

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

Description of Violation

On 03/09/25, at approximately 9:45 AM, the lights in stairwell #2 on the second and third floors were not working.

On 03/09/25, at approximately 9:47 AM, the light in the toilet room inside the second floor spa bathroom was very dim to the point when the door was closed, the room was in almost complete darkness.

87 - Lighting *(continued)*

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

• 3/9/2026 The lightbulbs were replaced during the survey upon identification. An audit of all stairwells was completed to ensure no other lights were out and replacement made if indicated.
• 3/26/2026: Executive Director reeducated management team to this regulation.
• 4/22/2026: Executive Director, designee will in-service staff to this regulation during Town Hall. Town Hall reeducation will continue x 3 months.
• 4/30/2026: Facility Audit Tool to address and correct this violation will be used 3 x a week x 4 weeks; 1 x a week for 4 weeks; 1 x a month for 1 month. Audits will be reviewed during monthly QA meetings.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented (07/20/2026)

88a - Surfaces

18. Requirements

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

Description of Violation

On , at approximately 9:47 AM, the ceiling inside the second floor spa bathroom was peeling.

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

• 4/13/2026: Remediation of second floor spa ceiling completed.
• 4/22/2026: Executive Director, designee will in-service staff to this regulation during Town Hall. Town Hall reeducation will continue x 3 months.
• 4/30/2026: Facility Audit Tool to address/correct and ensure ongoing compliance will be used 3 x a week x 4 weeks; 1 x a week for 4 weeks; 1 x a month for 1 month. Audits will be reviewed during monthly QA meetings.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented - 07/20/2026)

107c - Food/Water 3 Day Supply

19. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On , the home served 72 residents, requiring 216 gallons of emergency drinking water. However, the home had only 155 gallons. The home's contract with a local bottled water supplier, dated January 1, 2026, includes the phrase "It is strongly recommended that your facility have an alternate back-up water agreement with another purveyor, as our capability to distribute mass quantities of bottled water is limited.". The home does not have an alternate back-up contract with another company.

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

• 3/17/2026: The facility was replaced the 3-day emergency drinking water with needed of 100% capacity.
• 4/22/2026: Executive Director, designee will in-service staff to this regulation during Town Hall. Town Hall reeducation will continue x 3 months.
• 4/30/2026: Facility Audit Tool to address/correct and ensure ongoing compliance will be used 3 x a week x 4

107c Food/Water 3 Day Supply (continued)

weeks; 1 x a week for 4 weeks; 1 x a month for 1 month. Audits will be reviewed during monthly QA meetings.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

107d - Procedure Emergency Management Agency Submission

20. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home submitted an emergency management plan to the local emergency management agency on [redacted] while licensing representatives were onsite. Prior to this submission, the home's written emergency procedures had not been reviewed, updated or submitted to the local emergency management agency since [redacted]

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

• 3/11/2026 The facility submitted the emergency management plan to the local emergency management agency. Documentation of submission and email confirmation has been retained on site.

• 4/10/2026: Executive Director has scheduled standardized Emergency Preparedness Compliance Calendar Annual emergency plan review for August's QA meetings. Submission of the plan is scheduled for December of each year and added to QA agenda.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

132d - Evacuation

21. Requirements

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

Description of Violation

During the fire drill on [redacted] at 9:04 AM, 80 residents were present in the home but only 79 residents are documented as evacuated. During the fire drill on [redacted] at 8:07 PM, 84 residents were present in the home but only 83 residents are documented as evacuated. Documentation indicates there was a hospice resident in the home during these drills that could not evacuate but the home could not provide documentation from a physician indicating the resident was actively dying and may suffer bodily injury or a hastened death as a result of participating in the fire drills or written informed consent from the resident, the resident's power of attorney for health care, the resident's legal guardian or the resident's health care representative that the resident is not to evacuate in a fire drill.

Repeat Violation: [redacted], et. al.

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

• 3/11/2026: There was no potential to evacuate the unidentified hospice residents after the survey.

• 3/28/2026: Executive Director met with Fire & Life Safety Expert who facilitates the facility's monthly drill. Executive Director reviewed the preliminary findings of the survey including the anticipated violation regarding the 5/9/25

132d - Evacuation (continued)

and 6/24/25 failure to evacuate unidentified hospice residents and the regulation requiring all resident to evacuate, or facilities' need to obtain physician documentation indicating that a hospice residents is actively dying and may suffer bodily injury or hastened death as a result of participating in fire drills and written informed consent from the resident or their representative that the resident is not to evacuate in a fire drill. Fire & Life Safety Expert facilitated March's fire drill. All residents were evacuated during this drill.

• 4/7/2026: Fire & Life Safety Expert facilitated April's fire drill. Executive Director confirmed all residents were evacuated.

• 4/29/2026: Fire & Life Safety All-Staff Annual Training scheduled for all 3 shifts.

• 4/30/2026: An audit of fire drills to assess residents evacuated will be completed by the ED or designee monthly x 3 months, results reviewed at the monthly QA meeting.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

132h - Designated Meeting Place

22. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on [redacted] at 5:47 PM, residents who were seated in the dining room having dinner were told to stay seated and did not evacuate. Staff person F confirmed that the "fire" was staged in the back hall of the 3rd floor and residents were safe in the dining room and did not have to evacuate. Staff person F also stated if they aren't in the fire zone, they don't have to evacuate and that a head count had been completed.

During an interview, resident [redacted] indicated that they had participated in only one fire drill and returned to their room before the fire drill was completed. All other drills, the resident stays in their room due to physical ailments. Resident [redacted] stated staff lean into the apartment, wave and tell the resident they are tagging the resident's door. Resident [redacted] has lived at the home since [redacted].

Repeat Violation: [redacted] et. al.

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

• 3/28/2026: Executive Director met with Fire & Life Safety Expert. Executive Director reviewed the preliminary findings of the survey including the anticipated violation regarding the 2/25/2026 failure to move residents from the fire safe zone of the dining room to the fire safe zone of the lobby. Fire & Life Safety Expert stated [redacted] would ensure this occurred from this drill forward. Fire & Life Safety Expert facilitated March's fire drill. Resident [redacted] did participate in the drill. All residents evacuated to a fire safe zone in the community.

• 4/7/2026: Fire & Life Safety Expert facilitated April's fire drill. Executive Director confirmed all residents moved from the dining fire safe zone to the lobby fire safe zone or another fires safe zone in the community. were moved to a fire-safe zone. Resident [redacted] did participate in the drill.

• 4/13/2026: Executive Director will meet with Resident [redacted] and review this LIS with Resident [redacted] provide Resident [redacted] with a copy of this regulation to reinforce understanding and continued participation with Fire Drills and other planned or unplanned trainings/evacuations.

• 4/29/2026: Fire & Life Safety All-Staff Annual Training scheduled for all 3 shifts.

• 4/30/2026: An audit of fire drills to assess residents evacuated will be completed by the ED or designee monthly x

132h - Designated Meeting Place (continued)

3 months, results reviewed at the monthly QA meeting.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

141a - Medical Evaluation

23. 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] medical evaluation, completed [redacted], did not include an indication that the resident's needs can be met safely at the Personal Care Home.

Resident [redacted] medical evaluation, completed [redacted] and signed [redacted], indicates that the resident is Nursing Facility Clinically Eligible (NFCE). Services to be provided at home or in a nursing facility. The resident's needs can not be met safely at the Personal Care Home.

Repeat Violation [redacted] et al

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

• 2/25/2026: Resident [redacted] medical evaluation was updated based on facility self-identified audit and includes the documentation that [redacted] needs could be met in a personal care home.
• 2/25/26: 2/25/26: Resident [redacted] will see [redacted] primary care physician (PCP) on 4/15/2026. The PCP will complete a new medical evaluation form.
• 4/1/2026: Executive Director or designee will audit all admission paperwork, prior to the residents' move in to ensure the DME indicated needs can be met in personal care home. Audits will be reviewed monthly during QA meetings.
• 4/8/26: Executive Director engaged Upper Perk Partners consulting services to conduct an audit of current residents' DME to determine if all DMEs are compliant and the residents' needs can be met in personal care home.
• 4/16-4/24/2026: UPP consultant to conduct audit of all residents' charts. The Executive Director will review results and report during monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

162c - Menus Posted

24. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On [redacted] the home's menus for the weeks of [redacted] to [redacted] and [redacted] to [redacted] were posted. However, the menu for the following week was not posted.

162c - Menus Posted (continued)

On [redacted] only the home's menu for the current week, [redacted] to [redacted], was posted in the memory care unit. The menu for the following week was not posted.

Repeat Violation: [redacted] et. al.

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

• 3/9/2026: The facility corrected the menu postings in PC and MC during survey and
• 3/10/2026: Culinary Director now posts a rolling three-week schedule of menus in Personal Care and Memory Care.
• 4/22/2026: Executive Director, designee will in-service staff to this regulation during Town Hall. Town Hall reeducation will continue x 3 months.
• 4/22/2026: Facility POC Audit Tool will be used 3 x a week x 4 weeks; 1 x a week for 4 weeks; 1 x a month for 1 month to assess for correct menu postings in personal and memory care. Results will be reviewed at the monthly QA meeting.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented[redacted] 07/20/2026)

183b - Meds and Syringes Locked

25. Requirements

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

Description of Violation

On [redacted] at approximately 10:00 AM, a medication cart (med-cart) was unlocked, unattended, and accessible in the memory care unit.

Repeat Violation: [redacted], et. al.

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

• 3/9/2026 The Memory Care medication cart was locked upon identification of the issue during the survey.
• 4/22/2026: Executive Director or designee will review this violation and reinforce that all medication carts remain locked while unattended. This topic will continue to be reviewed at Town Halls x 3 months.

• 4/22/2026: Facility POC Audit Tool will be used to monitor compliance weekly x 4 weeks, monthly x 2 months, results reviewed during monthly QA meeting.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented[redacted] - 07/20/2026)

183d - Prescription Current

26. Requirements

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

183d Prescription Current *(continued)*

Description of Violation

On [redacted], the following discontinued (dc'd) medications were observed on the med carts:

For resident [redacted]

- *[redacted] Take 2 tablets by mouth in the morning, take 1 tablet by mouth in the evening, dc'd on [redacted]*
- *[redacted] Take 1 tablet by mouth once daily. dc'd on [redacted]*
- *[redacted] Take 1 tablet by mouth two times daily, dc'd on [redacted]*

For resident [redacted]

- *[redacted] Take 1 Tablet by mouth once daily, dc'd on [redacted]*

For resident [redacted]

- *[redacted] Take one tablet by mouth once a day at 6 AM, dc'd date unknown, not a current prescription,*
- *[redacted] Take one Tablet by mouth daily in the morning, dc'd on [redacted],*
- *[redacted] Take 1 tablet by mouth daily, dc'd on [redacted].*

Repeat Violation: [redacted], et. al.

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

• 3/12/26: Resident [redacted] medications [redacted] and [redacted] were removed from the cart and disposed of per facility policy.
• 3/12/26: Resident [redacted] was removed from the cart and disposed of per facility policy.
• 3/12/26: Resident [redacted], [redacted] and [redacted] were removed from the cart and disposed of per facility policy.
• 4/6/2026 4/24/2026: All med techs and nurses will be trained on this regulation, how to audit a med cart utilizing a physician order sheet (POS) to ensure all active ordered medications are available on the cart, to remove all discontinued medications, medication re ordering, how to remove medications & treatments upon discontinuation, documentation on the MAR and to ensure blister cards do not have any punctures in the back. Discontinued, expired and/or damaged medication will be removed from the cart.
• 4/27/2026: Six medication administration staff members will audit one POS five days a week until 100% of resident's POS have been audited x 3 months. Audits will be turned in daily to Health Care Coordinator, medications not available will be ordered, reordered, PCP will be communicated with for order revisions and any other remediation
will occur on the same day. Results will be added to HCC report that is scanned to the Executive Director daily x 3 months
• 4/1/2026: POS audits will be reviewed during monthly Quality Assurance Meetings monthly x 3 months.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented[redacted] - 07/20/2026)

183e - Storing Medications

27. Requirements

183e - Storing Medications *(continued)*

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 [redacted] during the medication audits, loose pills were observed on three separate carts;

- *1 loose pill in the 2nd drawer of the memory care unit's med-cart,*
- *19 loose pills of various shapes, sizes and colors on the 2nd floor "small cart",*
- *On the third floor med-cart, a loose half pill in the 3rd drawer and a loose half pill in the narcotics box.*

Resident [redacted] is prescribed [redacted] - Take 3 capsules by mouth at bedtime. On [redacted] during a medication cart audit, a tear in slot #9 on the blister pack for this medication was observed. The medication was present in the package.

On [redacted] a [redacted] prescribed for resident [redacted] was open with an open date of [redacted] According to the manufacturer's instructions this medication can be used for 28 days after opening.

On [redacted] a [redacted] prescribed for resident [redacted] was observed open on the third floor med-cart. An open date had been written on the FlexPen; however, the information was no longer legible. According to the manufacturer's instructions this medication can be used for 28 days after opening.

On [redacted], a bag of [redacted] prescribed for resident [redacted] have a use by date of [redacted]

On [redacted], a bag of 18 [redacted] oral syringes prescribed for resident [redacted] which were briefly taken by staff person A but returned when requested for the medication audit, had an expiration date of [redacted]

Repeat Violation [redacted] et. al.

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

• 3/10/2026 All loose pills were removed from the carts and disposed of per facility policy during the survey.
• 3/10/2026 Resident [redacted] slot 9 medication was removed and disposed of per facility policy during the survey. The Lantus Solostar Pen was discarded during survey.
• 3/10/2026 Resident [redacted] was discarded during survey.
• 3/10/2026: Resident [redacted] was discarded and medication discontinued during survey.
• 3/10/2026: Resident [redacted] was discarded during survey.
• 4/6/2026 – 4/24/2026: All med techs and nurses will be trained on this regulation, how to audit a med cart utilizing a physician order sheet (POS) to ensure all active ordered medications are available on the cart, to remove all discontinued medications, medication re-ordering, how to remove medications & treatments upon discontinuation, documentation on the MAR and to ensure blister cards do not have any punctures in the back. Discontinued, expired and/or damaged medication will be removed from the cart.
• 4/27/2026: Six medication administration staff members will audit one POS five days a week until 100% of resident POS have been audited x 3 months. Audits will be turned in daily to Health Care Coordinator, medications not available will be ordered, reordered, PCP will be communicated with for order revisions and any other remediation will occur on the same day. Results will be added to HCC report that is scanned to the Executive Director daily x 3 months
• 4/1/2026: POS audits will be reviewed during monthly Quality Assurance Meetings monthly x 3 months.

183e - Storing Medications *(continued)*

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

185a - Implement Storage Procedures

28. 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 [redacted] during a medication audit, the glucometers for residents [redacted] and [redacted] were all noted to be one hour behind the correct time.

On [redacted], during a medication audit, the following transcription errors were noted in resident [redacted]s March 2026 MAR;

- *On [redacted] at 4:27 PM, a blood sugar reading of [redacted] was listed on resident [redacted] glucometer but was documented at [redacted]*
- *On [redacted] at 4:26 PM, a blood sugar reading of [redacted] was listed on resident [redacted] glucometer but was documented at [redacted].*

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

• 3/10/2026: All residents received a new glucometer, set with the correct time, after survey.
• 4/14/2026: Regional Nurse will train medication administration staff on no shared glucometer used in facility, glucometer use, how to audit glucometers against the documented readings, documentation of reading in MAR. Training will be on-going until all medication administration staff are trained.
• 4/19/2026: HCC or designee will conduct glucometer audits weekly x 4 weeks, then monthly x 2 months to ensure residents blood glucose documentation in the MAR is consistent with the glucometer reading. Results will be reviewed during monthly QA meetings

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

29. 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

Resident [redacted] is prescribed [redacted] - Inhale 1 vial via nebulizer every 6 hours as needed. On [redacted] this medication was not available in the home.

On [redacted] during the medication audit, the following problems were discovered:

185a Implement Storage Procedures (continued)

Staff person B stated they counted 18 [redacted] syringes for resident [redacted] at the start of their shift. When the medication audit was being completed, these syringes were not in the respective refrigerator. It was then discovered that staff person A had removed the syringes, without telling staff person B, because they were expired. Staff person B indicated that they are uncomfortable with other people having keys to the medications for which staff person B is responsible.

At 1:29 PM, the "Controlled Drug Record" for resident [redacted] lists 5 pills remaining but the blister pack for this medication had 4 pills remaining.

At 1:31 PM, the "Controlled Drug Record" for resident [redacted] "Morning" [redacted] Tablet lists 16 pills remaining but the blister pack for this medication had 15 pills remaining. The "Bedtime" record for this same medication lists 21 pills remaining but the blister pack contains 20 pills. Additional concern with this medication; the home originally received a total of 60 pills between the "Morning" and "Bedtime" blister packs. Instead of starting at 30 pills for the "Morning" Controlled Drug Record, the count starts with 23 pills and a line through pills numbered 30 to 24. The "Bedtime" Controlled Drug Record starts with 28 pills instead of 30. No explanation is available for the missing pills.

At 1:40 PM, the "Controlled Drug Administration Record" for resident [redacted] lists 15 pills remaining but the blister pack for this medication had only 14 pills remaining. Staff person F stated this medication had been administered that morning and failed to document the administration. Staff person F signed the medication out during the audit.

The home's controlled substance policy indicates the following:

- a. All administrations of a Controlled Substance, whether scheduled or PRN, is documented on the MAR.
- b. When Controlled Substances are removed from the original packaging (bubble pack, vial, etc.), it is documented on the Controlled Substance Medication Record including: i. Date. ii. Time. iii. Quantity used. iv. Quantity remaining. v. Staff initials."

Repeat Violation [redacted]

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

• 3/9/2026: Facility replaced all glucometers with new glucometers for each resident.
• 4/12/2026: Executive Director confirmed Resident [redacted] is in the community, available to resident as ordered
• 3/10/2026: Resident [redacted] expired [redacted] syringes were wasted per facility policy.
• 3/10/2026: Resident [redacted], resident [redacted] and resident [redacted] were reconciled and corrected during the shift change narcotic count.
• 4/12/2026: Executive Director confirmed Resident [redacted] is in the community, available to resident as ordered.
• 4/14/2026: Regional Nurse will reeducate medication administration staff to sign out medication on the narcotic sheet and MAR at the time medications are given.
• 4/14/26: Regional Nurse will train medication administration staff on no shared glucometer used in facility, glucometer use, how to audit glucometers against the documented readings, documentation of reading in MAR. Training will be on going until all medication administration staff are trained

185a - Implement Storage Procedures (continued)

• 4/19/26: HCC or designee will conduct glucometer audits weekly x 4 weeks, then monthly x 2 months to ensure all residents have their own glucometer. Results will be reviewed during monthly QA meetings

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

187a - Medication Record

30. Requirements

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident [redacted] is prescribed [redacted] Tablet - Take 1 tablet by mouth daily. However, the resident's March 2026 medication administration record does not indicate the diagnosis or purpose for this medication.

Resident [redacted] is prescribed [redacted] - Take 1 tablet by mouth on Mon-Wed-Fri and [redacted] Capsule - Take 1 capsule by mouth every 6 hours as needed. However, the resident's March 2026 medication administration record does not indicate the diagnosis or purpose for these medications.

Resident [redacted] prescribed [redacted] - Dissolve 17 GM in 8 ounces of fluid and drink by mouth once a day. However, the resident's March 2026 medication administration record lists the above instructions but lists the time of administration as "As Needed". Due to the conflicting instructions, this medication had not been administered in March 2026.

Resident [redacted] is prescribed [redacted] - Instill 1 drop in affected eye(s) at bedtime. This medication is documented as administered on [redacted] at 8:31 PM; however, the notations on the resident's March 2026 medication administration record indicate this medication was "on order" on [redacted] and on [redacted] and not available in the home. On [redacted], the notations indicate a delivery was received and the medication administered. In addition to being noted "on order" on [redacted] the notations also indicate the medication was "Refused by Resident".

Repeat Violation: [redacted], et. al.

187a - Medication Record *(continued)*

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

• 4/4/2026: Resident transferred to a skilled nursing facility. Resident has not been discharged at this time, and the family is still removing personal items from apartment.
• 3/4/2026: Resident s provider updated the diagnosis for the order to anemia unspecified.
• 4/10/2026: Resident s order states it is given for constipation. Order has been corrected to a standard order.
• 4/10/2026: Resident# is currently receiving drops as ordered.?
• 4/6/2026 – 4/24/2026: All med techs and nurses will be trained on this regulation, how to audit a med cart utilizing a physician order sheet (POS) to ensure all active ordered medications are available on the cart, to remove all discontinued medications, medication re-ordering, how to remove medications & treatments upon discontinuation, documentation on the MAR and to ensure blister cards do not have any punctures in the back. Discontinued, expired and/or damaged medication will be removed from the cart.
• 4/27/2026: Six medication administration staff members will audit one POS five days a week until 100% of resident POS have been audited x 3 months. Audits will be turned in daily to Health Care Coordinator, medications not available will be ordered, reordered, PCP will be communicated with for order revisions and any other remediation will occur on the same day. Results will be added to HCC report that is scanned to the Executive Director daily x 3 months
• 4/1/2026: POS audits will be reviewed during monthly QA meetings x 3 months.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented - 07/20/2026)

187b - Date/Time of Medication Admin.

31. Requirements

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

Description of Violation

Resident is prescribed - Take 1 Tablet by mouth at bedtime, Capsule - Take 3 capsules (75 MG) by mouth at bedtime, - Inject 22 units sub-q every night at bedtime, in addition to other medications. Resident s March 2026 medication administration record does not include the initials of the staff person who administered these medications on March 3, 2026 at 8:00 PM.

Resident is prescribed Tablet - Take 1 tablet by mouth twice daily as needed. The following administrations were not documented on resident March 2026 medication administration record but are documented on the Controlled Drug Record: at 0845, at 2100, at 2100, at 0800, at 0900 and 2100 and at 0830.

Staff person F did not immediately document blood pressure readings from residents and

Repeat Violation: et. al.

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

• 3/10/2026: Medication Nurse for Resident was recalled to the facility and signed /initialed on the paper MAR.
• 3/10/2026: Community acknowledges medication nurse for Resident signed the narcotic log for administration of Lorazepam but did not sign the electronic MAR on this day. Staff person F no longer works in the facility

187b Date/Time of Medication Admin. (continued)

• 4/14/26: Regional Nurse will train medication administration staff on narcotic log documentation and reviewing the Not Charted Report that will identify any missing or omitted signatures. Training will be on going until all medication administration staff are trained.

• 4/19/26: HCC or designee will conduct narcotic log audits and audit the Not Charted Report weekly x 4 weeks, then monthly x 2 months. Results will be reviewed during monthly QA meetings.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

187d - Follow Prescriber's Orders

32. Requirements

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

Description of Violation

Resident [redacted] did not receive the following medications as prescribed on the dates listed below because the medication was not available in the home:

- *[redacted] Take 1 tablet by mouth daily. This medication was not administered between [redacted] through [redacted]*
- *[redacted] Take 1 tablet by mouth twice a day. This medication was not administered between [redacted] and [redacted] and again on [redacted] at 8:00 PM*
- *[redacted] Take one tablet by mouth twice daily. This medication was not administered on [redacted] and [redacted] at 8:00 AM and at 8:00 PM on [redacted] and [redacted]*
- *[redacted] Apply a thin layer of cream to affected area (rash area) under the bilateral breasts and groin area twice daily. This medication was not administered at 8:00 AM on [redacted] to [redacted], [redacted] to [redacted], and [redacted] The 8:00 PM administration was missed on [redacted] to [redacted], and to [redacted]*
- *[redacted] Take 1 tablet by mouth twice daily. This medication was not administered on [redacted] and [redacted] at 8:00 AM.*

Resident [redacted] is prescribed [redacted] 4x4 Apply to buttocks area until healed. This medication was not administered on [redacted] but continued on [redacted].

Resident [redacted] was administered [redacted] Inject [redacted] sub q every night at bedtime on [redacted] however, this medication should have been discarded on [redacted], 28 days after being opened on [redacted]

Resident [redacted] is prescribed [redacted] Inject [redacted] under the skin once weekly on Thursday. This medication was not administered on Thursday [redacted] because the medication was not available in the home.

Resident [redacted] is prescribed [redacted] Dissolve 17 gm in 8 ounces of fluid and drink by mouth once a day. This medication was not administered between [redacted] and [redacted] because the medication administration record says it is to be administered as needed. The Physician's order states dissolve 17 gm in 8 oz of fluid and drink by mouth once a day.

Resident [redacted] is prescribed [redacted] Take 1 tablet once daily at noon. However, on [redacted], this

187d - Follow Prescriber's Orders (continued)

medication was not administered until 2:10 PM.

Resident [redacted] is prescribed [redacted] - Take on[e] tablet by mouth twice for pain. This medication was not administered on [redacted] at 8:00 PM, "waiting on arrival from pharmacy" is documented on the resident's medication administration record; however, the medication was available in the home.

Resident [redacted] is prescribed [redacted] - Instill 1 drop in affected eye(s) at bedtime. This medication was not administered on [redacted] and [redacted] because the medication was not available in the home.

Repeat Violation [redacted].

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

• 2/3/2026: Resident [redacted] discharged from the facility.
• 4/4/2026: Resident [redacted] transferred to a skilled nursing facility. Resident [redacted] has not been discharged at this time, and the family is still removing personal items from [redacted] apartment.
• 3/6/2026: Resident [redacted] primary care physician placed a hold order on [redacted] due to family not approving the co-pay. Family requested a change to the medication.
• 3/18/2026: Resident [redacted] was discontinued.
• 4/10/2026: Resident [redacted] order was corrected to 1 x a day and not PRN.
• 4/10/2026: The Executive Director confirmed Resident [redacted] is using new [redacted]. The old medication was discarded.
• 4/10/2025: Executive Director confirmed Resident [redacted] is currently receiving [redacted] on time.
• 4/10/2026: Executive Director confirmed Resident [redacted] is currently receiving [redacted] as ordered.
• 4/10/2026: Resident [redacted] is now receiving [redacted] eye drops as ordered.
• 4/6/2026 – 4/24/2026: All med techs and nurses will be trained on this regulation, how to audit a med cart utilizing a physician order sheet (POS) to ensure all active ordered medications are available on the cart, to remove all discontinued medications, medication re-ordering, how to remove medications & treatments upon discontinuation, documentation on the MAR and to ensure blister cards do not have any punctures in the back. Discontinued, expired and/or damaged medication will be removed from the cart.
• 4/27/2026: Six medication administration staff members will audit one POS five days a week until 100% of resident POS have been audited x 3 months. Audits will be turned in daily to Health Care Coordinator, medications not available will be ordered, reordered, PCP will be communicated with for order revisions and any other remediation will occur on the same day. Results will be added to HCC report that is scanned to the Executive Director daily x 3 months, POS audits will be reviewed during monthly QA meetings x 3 months.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] 07/20/2026)

188b - Medication Error Reporting

33. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident [redacted] did not receive the following medications as prescribed on the dates listed below because the medication

188b - Medication Error Reporting (continued)

was not available in the home:

[redacted] - Take 1 tablet by mouth daily. This medication was not administered between [redacted] through [redacted] - Take 1 tablet by mouth twice a day. This medication was not administered between [redacted] and [redacted] and again on [redacted] at 8:00 PM [redacted] - Take one tablet by mouth twice daily. This medication was not administered on [redacted] and [redacted] at 8:00 AM and at 8:00 PM on [redacted] and [redacted] [redacted] - Apply a thin layer of cream to affected area (rash area) under the bilateral breasts and groin area twice daily. This medication was not administered at 8:00 AM on [redacted] to [redacted] to [redacted] and [redacted]. The 8:00 PM administration was missed on [redacted] to [redacted], and [redacted] to [redacted] [redacted] - Take 1 tablet by mouth twice daily. This medication was not administered on [redacted] and [redacted] at 8:00 AM.

Resident [redacted] is prescribed [redacted] - Apply to buttocks area until healed. This medication was not administered on [redacted] but continued on [redacted].

Resident [redacted] was administered [redacted] Inject [redacted] sub-q every night at bedtime on [redacted] however, this medication should have been discarded on [redacted], 28 days after being opened on [redacted].

Resident [redacted] is prescribed [redacted] Dissolve [redacted] in 8 ounces of fluid and drink by mouth once a day. This medication was not administered between [redacted] and [redacted] because the medication administration record says it is to be administered as needed. The Physician's order states dissolve [redacted] in 8 oz of fluid and drink by mouth once a day.

Resident [redacted] is prescribed [redacted] - Take 1 tablet once daily at noon. However, on [redacted], this medication was not administered until 2:10 PM.

Resident [redacted] is prescribed [redacted] - Take on[e] tablet by mouth twice for pain. This medication was not administered on [redacted] 8:00 PM, "waiting on arrival from pharmacy" is documented on the resident's medication administration record; however, the medication was available in the home.

Resident [redacted] is prescribed [redacted] - Instill 1 drop in affected eye(s) at bedtime. This medication was not administered on [redacted], and [redacted] because the medication was not available in the home.

These medication errors were not reported to the prescriber.

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

- 2/3/2026: Resident [redacted] was discharged from the facility.
- 4/10/2026: Resident [redacted] Resident [redacted] transferred to a skilled nursing facility. Resident [redacted] has not been discharged at this time, and the family is still removing personal items from [redacted] apartment.
- 4/9/2026: Resident [redacted] PCP notified of med error; Resident [redacted] PCP notified of med error. Resident [redacted] PCP notified of med error. Resident [redacted] PCP notified of med error. Resident [redacted] PCP notified of med error.
- 4/14/26: Regional Nurse will train medication administration staff to notify the provider of a resident of the

188b - Medication Error Reporting (continued)

resident does not receive their medication. Training will be on-going until all medication administration staff are trained.

• 4/19/26: HCC or designee will audit no pass medication report weekly x 4 weeks, then monthly x 2 months. Results will be reviewed during monthly QA meetings

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented (- 07/20/2026)

225a - Assessment 15 Days

34. Requirements

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

Description of Violation

Resident was admitted on ; however, the resident's assessment was not completed until

Resident was admitted on ; however, the resident's assessment was not completed until .

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

• October 2025-January 2026: Due to the ongoing audits from October 2025 to January 2026 resident assessments and support plans identified as overdue were completed to get back on schedule, they will still reflect the identified overdue status of resident assessments and support plans during this time.

• 4/10/2026: A notification of any identified needed corrections will be placed in the residents' records to alert surveyors and other providers of the past non-compliance these late assessments were done to correct.

• 12/5/2025: Resident resident assessment was completed after facility identified need via internal audit.

• 2/3/2026: Resident was discharged from the facility.

• 4/8/26: Executive Director engaged Upper Perks Partners to audit all current residents' charts for compliance with the 15-day assessment.

• 4/16-24/2026: Upper Perks Partners will audit all charts for compliance

• 4/10/2026: 15-Day New Admission Tracker was added to the Managers Morning Meeting Agenda to ensure the interdisciplinary team maintains awareness of the timeframe.

• 4/10/2026: Executive Director or designee will audit new admissions prior to the 15-day assessment due date to ensure compliance monthly x 3 months. Audits will be reviewed during QA meetings x 3 months.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented 07/20/2026)

225c - Additional Assessment

35. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

225c - Additional Assessment (continued)

Resident [redacted] current assessment was completed on [redacted] However, the resident's previous assessment was completed on [redacted].

Repeat Violation: [redacted], et. al.

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

October 2025-January 2026: Due to the ongoing audits from October 2025 to January 2026 resident assessments and support plans identified as overdue were completed to get back on schedule, they will still reflect the identified overdue status of resident assessments and support plans during this time.

• 4/10/2026: A notification of any identified needed corrections will be placed in the residents' records to alert surveyors and other providers of the past non-compliance. These late assessments were done to correct.

• 12/4/2025: Resident [redacted]s resident assessment was completed due to an internal facility audit identifying the need.

• 4/8/26: Executive Director engaged Upper Perks Partners to audit all current residents' charts for compliance with the 15-day assessment.

• 4/16-24/2026: Upper Perks Partners will audit all resident charts for compliance

• 4/10/2026: 15-Day New Admission Tracker was added to the Managers Morning Meeting Agenda to ensure the interdisciplinary team maintains awareness of the timeframe.

• 4/10/2026: Executive Director or designee will audit new admissions prior to the 15-day assessment due date to ensure compliance monthly x 3 months. Audits will be reviewed during QA meetings x 3 months.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

227a - Support Plan 30 Days

36. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident [redacted] was admitted on [redacted]; however, the resident's initial support plan was not completed until [redacted]

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

• October 2025-January 2026: Due to the ongoing audits from October 2025 to January 2026 resident assessments and support plans identified as overdue were completed to get back on schedule, they will still reflect the identified overdue status of resident assessments and support plans during this time.

• 4/10/2026: A notification of any identified needed corrections will be placed in the residents' records to alert surveyors and other providers of the past non-compliance these late assessments were done to correct.

• 12/5/2025: Resident [redacted]s support plan was completed based on internal facility audit identifying the need.

• 4/1/2026: Executive Director/designee will audit all incoming Support Plans for signatures to ensure compliance. Audits will be reviewed during monthly QA meetings weekly x 4 weeks, then monthly x 2 months.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

227d - Support Plan Medical/Dental

37. Requirements

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

Description of Violation

The assessment for resident [redacted] dated [redacted], indicates the resident uses a bedside mobility device and includes the specific need and use of the device for Turning and positioning in bed/chair; however, "risks associated with the device, the resident's ability to use the device, identification of the specific device to be used and if a cover is required are not included on the Resident Assessment and Support Plan (RASP).

As a reference, the Resident Support Plan must include the following:

- *The specific need for the device,*
- *The intended Use,*
- *Any risks associated with the device,*
- *The resident's ability to use the device safely for the intended purpose,*
- *Identification of the specific device to be used,*
- *If a cover is required to meet FDA guidelines.*

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

• 3/9/2026: Resident [redacted] assessment and support plan were updated to reflect the specific need for device & the intended use.
• 4/10/2026: Resident [redacted] assessment & support plan was updated to reflect no risk was associated with the bed rail device that the device does not require a cover and the resident has the ability to safely use device for its intended purpose; Identification of the specific device used, If a cover is required to meet FDA guidelines.
• 4/8/26: Executive Director engaged Upper Perks Partners to audit all current residents' charts for bedside mobility device compliance, including: The specific need for the device; The intended use; Any risks associated with the device; The resident's ability to safely use device for its intended purpose; Identification of the specific device used; If a cover is required to meet FDA guidelines.
• 4/16-24/2026: Upper Perks Partners will audit all resident charts for compliance with the support plan's bed side mobility device care plan.
• 4/1/2026: Executive Director/designee will audit all new admission support plans for compliance with bed mobility device support planning. Audits will be reviewed during monthly QA meetings weekly x 4 weeks, then monthly x 2 months.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented ([redacted] 07/20/2026)

227g Support Plan Signatures

38. Requirements

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

Description of Violation

Resident [redacted] participated in the development of their support plan on [redacted] However, the resident did not sign the support plan.

227g Support Plan Signatures (continued)

Repeat Violation: [redacted].

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

• 4/10/2026: Executive Director audited the support plan and confirmed the 8/29/2025 support plan is now signed by Resident [redacted]

• 4/10/2026: A notification of any identified needed corrections will be placed in the residents' records to alert surveyors and other providers of the past non compliance these late assessments were done to correct.

• 4/8/26: Executive Director engaged Upper Perks Partners to audit all current residents' DMEs to ensure they have been signed by the resident, or acknowledge the residents were unable to sign.

• 4/16 4/24/2026: Upper Perks Partners will audit all resident charts for compliance

• May1, 2026: Executive Director/designee will audit all new admission's support plans for incoming for resident signatures. Audits will be reviewed during monthly QA meetings weekly x 4 weeks, then monthly x 2 months

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] ***- 07/20/2026)***

231c - Preadmission Screening

39. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident [redacted] *was admitted to the Secure Dementia Care Unit (SDCU) on* [redacted] *However, the resident's written cognitive preadmission screening is not dated.*

Repeat Violation: [redacted]

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

• 4/10/2026: Date and documentation of the correction was added to the preadmission screening from 10/9/2025.

• October 2025 January 2026: Due to the ongoing audits from October 2025 to January 2026 resident assessments and support plans identified as overdue were completed to get back on schedule, but they will still reflect the identified overdue status of resident assessments and support plans during this time.

• 4/10/2026: A notification of any identified needed corrections will be placed in the residents' records to alert surveyors and other providers of the past non compliance these late assessments were done to correct.

• 4/8/26: Executive Director engaged Upper Perks Partners to audit all current residents' charts for compliance with the 15 day assessment.

• 4/16 24/2026: Upper Perks Partners will audit all resident charts for compliance

• 4/1/2026: Executive Director/designee will audit all incoming preadmission screens to ensure compliance. Audits will be reviewed during monthly QA meetings weekly x 4 weeks, then monthly x 2 months

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] ***- 07/20/2026)***

234b - Support Plan Needs Elements

40. Requirements

234b - Support Plan Needs Elements *(continued)*

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The assessment for resident [redacted] dated [redacted] indicates the resident uses a bedside mobility device and includes the specific need and use of the device for Turning and positioning in bed/chair; however, risks associated with the device, the resident's ability to use the device, identification of the specific device to be used and if a cover is required are not included on the Resident Assessment and Support Plan (RASP).

As a reference, the Resident Support Plan must include the following:

- *The specific need for the device,*
- *The intended Use,*
- *Any risks associated with the device,*
- *The resident's ability to use the device safely for the intended purpose,*
- *Identification of the specific device to be used,*
- *If a cover is required to meet FDA guidelines.*

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

• 3/9/2026: Resident [redacted] RASP updated to reflect the specific need for the device, the intended use.
• 4/10/2026: Resident [redacted] RASP updated to reflect the device is a bed rail cane and does not require a cover; resident has the ability to use the device safely for the intended purpose (no risks associated with use).
• 4/24/2026: Executive Director will audit the RASPs of all residents who have a bed-side mobility device to ensure the support plan indicated: The specific need for the device; The intended use; Any risks associated with the device; The resident's ability to safely use device for its intended purpose; Identification of the specific device used; If a cover is required to meet FDA guidelines.
• 4/24/2026: All new admission documentation of medical evaluation will be reviewed by the Executive Director or designee prior to move-in date to ensure that if a bed mobility device is identified for use it is appropriately documented on the support plan indicating: The specific need for the device; The intended use; Any risks associated with the device; The resident's ability to safely use device for its intended purpose; Identification of the specific device used; If a cover is required to meet FDA guidelines.
• 4/24/2026: Documentation of the review of all new admissions DME will be retained on-site and reviewed during month QA meetings x 2 months.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented ([redacted] - 07/20/2026)

235 - Discharge/Transfer/Closure

41. Requirements

2600.
235. Discharge - If the home initiates a discharge or transfer of a resident, or the legal entity chooses to close the home, the administrator shall give a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This requirement shall be stipulated in the resident-home contract signed prior to admission to the secured dementia care unit.

Description of Violation

On [redacted], the home refused to let resident [redacted] return to the home. The home did not give the resident a 30-day notice.

235 - Discharge/Transfer/Closure *(continued)*

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

• 2/3/2026: Resident [redacted] was discharged from community.
• 3/26/26: Executive Director reeducated management team to this regulation.
• 4/15/2026: Executive Director/designee conducted a 100% audit of all discharges and pending move-outs within the last 30 days to ensure compliance with written notice requirements. Discharge Checklist is now required prior to any move-out, including written 30-day notice completed; resident/family signature obtained; copy placed in chart.
• 4/19/2026: Executive Director/designee will complete audits of all discharges weekly x 4 weeks, then monthly x 2 months.

Licensee's Proposed Overall Completion Date: *05/13/2026*

Implemented [redacted] - 07/20/2026)

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

July 20, 2026

[redacted]
KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC
[redacted]

RE: SPRING MILL SENIOR LIVING
3000 BALFOUR CIRCLE
PHOENIXVILLE, PA, 19460
LICENSE/COC#: 14632

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/18/2026, 05/19/2026 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: *SPRING MILL SENIOR LIVING* **License #**: *14632* **License Expiration**: *05/05/2026*

Address: *3000 BALFOUR CIRCLE, PHOENIXVILLE, PA 19460*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *09/10/2009* **Issued By**: *East Pikeland Township*

Type: *I-2* **Date**: *09/10/2009* **Issued By**: *East Pikeland Township*

Type: *Other* **Date**: *09/10/2009* **Issued By**: *East Pikeland Township*

Staffing Hours

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

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *05/19/2026*

Inspection Dates and Department Representative

05/18/2026 - On-Site: [redacted]

05/19/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98* **Residents Served**: *70*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *22* **Residents Served**: *18*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *70*

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

Have Mobility Need: *34* **Have Physical Disability**: *0*

Inspections / Reviews

05/18/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/25/2026*

Inspections / Reviews *(continued)*

06/30/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/18/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/18/2026*

07/20/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/18/2026*

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

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident [redacted] was unable to receive their [redacted] on [redacted] at 6:00 am due to their nebulizer machine being inoperable.

Repeated Violation - [redacted] et al.

Plan of Correction ***Accept [redacted] - 06/30/2026)***

• 4/11/2026: As a result of ongoing internal QA reporting, Resident [redacted]'s nebulizer was replaced by Healthcare Coordinator.
• 5/27/2026 – 5/31/2026: Initial audit of the care treatment history for the 3 residents with nebulizer orders who reside in the community, confirming all treatments were provided and nebulizers were in working order.
• Starting 6/1/2026: Clinical Specialist or designee will conduct weekly audits of care history treatments for residents utilizing a nebulizer x 4 weeks x 2 months. Results will be reviewed during corresponding monthly QA meetings x 2 months.
• 6/2/2025: Regional nurse purchased 2 new nebulizers to replenish community inventory.
• Starting 6/14/2026: To ensure ongoing compliance medication administration staff members will be in-serviced by the Executive Director, or designee on how to conduct assigned POS to MAR to CART to ROOM audits. In-service will include the expected documentation and follow-up for 81b, that the auditor must enter resident's unit, identify that any wheelchairs, walkers, nebulizer and any other apparatus used by resident is in good repair. If a nebulizer or if any other apparatus is found to be inoperable the staff must immediately notify a supervisor who will replace the broken nebulizer with a nebulizer from the community's inventory.
• Starting 6/14/2026 the Executive Director or designee will assign 10 audits weekly x 10 weeks. Results of these audits will be reviewed during corresponding QA meeting x 2 months.
• Starting 6/21/2026: Resident Care Coordinator (RCC) or designee will review the audits weekly x 10 weeks and report concerns identified to the Director of Health & Wellness (DHW) or designee for immediate action. Results will be reviewed during weekly meeting between Executive Director (ED), Resident Care Coordinator and DHW weekly x 10 weeks. Results will be reviewed during corresponding monthly QA meetings x 2 months.
• Starting 6/21/2026: Executive Director or designee will in-service medication administration staff to the 5/18/2026 LIS violation report to ensure there is department wide understanding of this regulation and how the POS to MAR to CART to ROOM audits are in place to ensure ongoing compliance.
• 6/30/2026: POC progress will be reviewed during monthly QA meeting x 2 months.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] 07/20/2026)

82c - Locking Poisonous Materials

2. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

82c Locking Poisonous Materials *(continued)*

Description of Violation

Head and Shoulders 2 in 1, with a manufacture's label indicating "if swallowed get medical help or contact a poison control center right away", was unlocked, unattended, and accessible to residents in resident room [redacted]. Not all the residents of the home, including resident [redacted] have been assessed capable of recognizing and using poisons safely.

Colgate Optic White, with a manufacture's label indicating "if more than used for brushing is accidentally swallowed, get medical help or contact a poison control center right away", was unlocked, unattended, and accessible to residents in resident room [redacted]. Not all the residents of the home, including resident [redacted] have been assessed capable of recognizing and using poisons safely.

Repeated Violation [redacted], et al.

Plan of Correction ***Accept [redacted] - 06/30/2026)***

• 5/18/2026: Resident [redacted] shampoo was locked in cabinet in the presence of the department representative.
• 5/18/2026: Resident [redacted] Colgate Optic White was locked in cabinet in the presence of the department representative.
• 5/18/2026: Executive Director notified Resident [redacted] POA that the resident's spouse, a personal care resident choosing to live with [redacted] in memory care, was no longer permitted to reside in memory care because [redacted] continued to unlock cabinets in the memory care unit occupied by Resident [redacted] Personal care spouse visits [redacted] in memory care as frequently as desired.
• 5/19/2026: Resident [redacted] spouse and personal belongings relocated to personal care. Executive Director audited memory care unit in its entirety to confirm all poisonous materials were secured behind a locked door or cabinet.
• Starting 5/19/2026: Identifying Poisonous Materials In Service for care staff, medication administration staff and housekeeping staff. In service will be ongoing until all care staff, medication administration staff and housekeeping staff have been trained.
• 5/28/2026: Executive Director in serviced staff during monthly Town Hall Identifying Poisonous Materials. In service will be ongoing until all care staff, medication administration staff and housekeeping staff have been trained.
• Starting 5/24/2026: Executive Director or designee in serviced Supervising Healthcare Coordinators to regulation 82c and the requirement to conduct compliance rounds in memory care daily. Memory Care Compliance Round added to the Daily Shift Report Supervising HCC are required to complete and turn in daily.
• Starting 6/24/2026: Executive Director and designee in service multiple team members across departments to conduct Memory Care 82c Verification Checklist Audits. Audits will take place 2 x a week x 10 weeks and be reviewed during corresponding QA meetings x 2 months.
• 6/24/2026: Executive Director prepared and Lead Concierges emailed notification to memory care responsible parties reviewing this violation and the requirement that poisonous materials be kept locked and inaccessible to residents unless all residents have been assessed as able to safely recognize and avoid such materials.
• 6/30/2026: POC progress will be reviewed during monthly QA meeting x 2 months.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented [redacted] 07/20/2026)

141b2 - Medical Evaluation Changes

3. Requirements

2600.
141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident [redacted]s most recent medical evaluation dated [redacted] did not have the medication addendum completed.

Plan of Correction ***Accept [redacted] - 06/30/2026)***

• 5/18/2026: During licensing inspection Resident[redacted] most recent medical evaluation with the attached medication addendum was presented to the department's representative.
• 6/19/2026: Compliance monitor for the community evaluated the LIS report, cross-referenced the POC audit that is part of on-going compliance efforts and refuted the accuracy of this tag. Executive Director emailed DHW Licensing Supervisor with a request to remove this tag, attached in the email was the DME dated 2/2/2026 and the Medication Addendum dated 2/5/2026.
• Starting June QA Meetings: Audit of new admissions DME, annual DME and change of condition DME will be reviewed to verify compliance x 2 months.
• Starting 6/29/2026: Clinical Specialist or designee will audit 8 current resident's DME's to ensure all DMEs have medication addendum completed weekly x 7 weeks (anticipated completion date for full audit).
• 6/30/2026: POC progress will be reviewed during monthly QA meeting x 2 months.

Proposed Overall Completion Date: 07/18/2026

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented [redacted] - 07/20/2026)

183b - Meds and Syringes Locked

4. Requirements

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

Description of Violation

On [redacted] at approximately 10:05 am, [redacted] and [redacted] were unlocked, unattended, and accessible in resident [redacted] room. Resident [redacted] has not been assessed to self-administer.

Repeated Violation - [redacted], et al.

Plan of Correction ***Accept [redacted] - 06/30/2026)***

• 5/18/2026: [redacted] and [redacted] were removed from resident [redacted] room.
• 5/18/2026: Regional nurse completed self-medication assessment for Resident[redacted]
• 5/18/2026: Regional nurse obtained order from PCP for resident to self-administer [redacted] and [redacted] Eye. These medications are available to resident to self-administer.
• Starting 5/19/2026: Identifying Poisonous Materials In-Service for care staff, medication administration staff and housekeeping staff. In-service will be ongoing until all care staff, medication administration staff and housekeeping

183b - Meds and Syringes Locked (continued)

staff have been trained.
• 5/28/2026: Town Hall included Identifying Poisonous Materials.
• 5/26/2026: Email family notification and posting alerting and reminding family and friends of the regulation that all ordered medications, over-the-counter medications, vitamins, supplements, eye drops, medicated creams and lotions, and herbal products, are only permitted in the community if delivered directly to the nursing team, reviewed, inventoried and obtained by the nursing team.
• 5/27/2026: Invitation to residents and family members to attend an information session with Executive Director and Ombudsman.
• 5/29/2026: Executive Director and Ombudsman discussed this requirement with personal care residents.
• 6/5 – 6/10/26: The Executive Director and designee conducted room checks in all personal care apartments to identify any prescription, OTC, CAM medications or syringes.
• Starting 6/14/2026 and ongoing: Clinical Specialist, Supervising HCC, DHW or designee will obtain any physician orders needed for any prescription, OTC, CAM medications to ensure compliance with this regulation.
• Starting 6/14/2026: To ensure ongoing compliance medication administration Executive Director or designee will in-service medication administration staff members on the requirement to conduct assigned POS to MAR to CART to ROOM audits. Specifically: 183b – Verify there are no OTC, Prescribed or CAM (complimentary alternative medicine) in residents' apartment that are not on the POS. Staff will be instructed to identify any of these medications on the audit forms, review the audit sheet with a supervisor for immediate action.
• Executive Director or designee will assign 10 audits weekly x 10 weeks.
• Starting 6/21/2026: RCC or designee will review the audits weekly x 10 weeks and report concerns identified to the DHW or designee for immediate action. Orders for residents to self-administer medications obtained as needed and if resident is assessed to do so. Results will be reviewed during weekly meeting between RCC and DHW weekly x 10 weeks. Results will be reviewed during corresponding monthly QA meetings x 2 months.
• Starting 6/21/2026: Executive Director or designee will in-service medication administration staff to the 5/18/2026 LIS violation report to ensure there is department wide understanding of this regulation and how the POS to MAR to CART to ROOM audits are in place to ensure ongoing compliance.
• 6/30/2026: POC progress will be reviewed during monthly QA meeting x 2 months.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented [redacted] - 07/20/2026)

183e - Storing Medications

5. 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 [redacted] [redacted] capsule belonging to resident [redacted] was punctured in spot 6 of the blister pack. The pill remained in the pack.

On [redacted] [redacted] tablet belonging to resident [redacted] was punctured in spot 10 of the blister pack. The pill remained in the pack.

183e - Storing Medications (continued)

On [redacted] tablet belonging to resident [redacted] had punctures in spots 23 and 25 of the blister pack. The pills remained in the pack.

On [redacted] tablet belonging to resident [redacted] had a puncture in spot 19 of the blister pack. The pill remained in the pack.

Repeated Violation - [redacted] et al.

Plan of Correction ***Accept [redacted] - 06/30/2026)***

• May 18/19, 2026: Resident [redacted] medications identified during the survey with punctures were removed and disposed of in the presence of the department representative.
• Starting June 2026: Clinical Specialist or designee will audit all carts 1 x a month x 2 months to ensure that any blister cards that had been identified with punctures through the weekly POS to MAR to CART to ROOM audits had been properly managed by removing the medication, destroying the medication and replacement request made to the pharmacy. Audits will be reviewed during corresponding QA meetings x 2 months.
• Starting 6/14/2026: To ensure ongoing compliance medication administration staff members will be in-serviced on the requirement to conduct assigned POS to MAR to CART to ROOM audits. Specifically: 183e – Verify there are no tears, punctures on the back of any blister cards in your cart (FOR THE ENTIRE CART). Executive Director or designee will assign 10 audits weekly x 10 weeks. Audits will be reviewed during corresponding QA meeting.
• Starting 6/21/2026: RCC will review the audits weekly x 10 weeks and report concerns identified to the DHW or designee for immediate action. Results will be reviewed during weekly meeting between RCC and DHW weekly x 10 weeks. Results will be reviewed during corresponding monthly QA meetings x 2 months.
• Starting 6/21/2026: Executive Director or designee will in-service regulation 183e and Preventing Tears in the Back of Blister Packs in-service to all medication administration staff.
• Starting 6/21/2026: Executive Director or designee will in-service medication administration staff to the 5/18/2026 LIS violation report to ensure there is department wide understanding of this regulation and how the POS to MAR to CART to ROOM audits are in place to ensure ongoing compliance.
• 6/30/2026: POC progress will be reviewed during monthly QA meeting x 2 months.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented [redacted] - 07/20/2026)

185a - Implement Storage Procedures

6. 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

Resident [redacted] is prescribed [redacted] tablet and [redacted] nasal spray as needed. On [redacted] these medications were not available in the home.

185a - Implement Storage Procedures (continued)

Resident[redacted] is prescribed [redacted] as needed. On [redacted] this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 06/30/2026)***

• 5/18/2026: Regional nurse contacted pharmacy for STAT order for Resident[redacted] and PCP for a review of the Naloxone order.
• 5/18/2026: Regional nurse Community obtained Resident [redacted] Nose Spray from local pharmacy.
• 5/19/2026: Resident [redacted] & [redacted] were delivered to community and available for administration as needed.
• 5/20/2026: Regional nurse received D/C Naloxone order for Resident[redacted]s from PCP.
• Starting 6/14/2026: To ensure ongoing compliance medication administration staff members will be in-serviced on the requirement to conduct assigned POS to MAR to CART to ROOM audits. Specifically: 185a – Verify PRN medications are available on the cart for the 2 POS audits if applicable, order the PRN medications if not available, alert supervisor immediately. Executive Director or designee will assign 10 audits weekly x 10 weeks. Results will be reviewed during corresponding QA meeting x 2 months.
• Starting 6/21/2026: RCC will review the audits weekly x 10 weeks and report concerns identified to the DHW or designee for immediate action. Results will be reviewed during weekly meeting between RCC and DHW weekly x 10 weeks. Results will be reviewed during corresponding monthly QA meetings.
• Starting 6/21/2026: Executive Director or designee will in-service medication administration staff to the 5/18/2026 LIS violation report to ensure there is department wide understanding of this regulation and how the POS to MAR to CART to ROOM audits are in place to ensure ongoing compliance.
• 6/30/2026: POC progress will be reviewed during monthly QA meeting x 2 months.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented[redacted] - 07/20/2026)

187a - Medication Record

7. Requirements

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

187a Medication Record *(continued)*

13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident [redacted] is prescribed [redacted] 3 times daily according to the following sliding scale: A blood sugar reading of [redacted] and to call the provider for a blood sugar over [redacted] This medication was administered from [redacted] to [redacted]; however, the insulin units are not included on resident [redacted]s medication administration record.

Repeated Violation [redacted], et al.

Plan of Correction ***Accept [redacted] 06/30/2026)***

• 5/18/2026: Regional Nurse added Resident [redacted] sliding scale order prompt and reviewed with department representative on June 19, 2026.
• 5/28/26: Clinical Specialist audited the MAR of all sliding scale residents to ensure accurate administration and recording of units administered.
• Starting 5/31/2026: Clinical Specialist will audit the MARS of the 3 sliding scale residents weekly x 10 weeks. Audits will be reviewed during corresponding monthly QA meetings.
• Starting 6/29/2026: Clinical Specialist or designee in service all HCCs to review and/or add, if needed, units given on all new or changed sliding scale insulin orders.
• 6/30/2026: POC progress will be reviewed during monthly QA meeting x 2 months.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented [redacted] 07/20/2026)

187b - Date/Time of Medication Admin.

8. Requirements

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

Description of Violation

On [redacted] during the 3:00 pm to 11:00 pm bedtime shift, resident [redacted] was administered [redacted] Staff person A did not initial at time of administration. The home uses electronic medication administration records (EMAR) and the initials were handwritten in.

On [redacted], during the 7:00 am to 3:00 pm shift, resident [redacted] was administered [redacted]. Staff person B did not initial at time of administration. Home uses electronic medication administration records and the initials were handwritten in.

On [redacted] at 11:55 am, resident [redacted] was administered [redacted] Tablet. Staff person A did not initial the EMAR until [redacted] at 11:01 pm.

On [redacted] at 11:00 am, resident [redacted] was administered [redacted], and [redacted] Staff person A did not initial the EMAR until [redacted] at 11:01 pm.

187b - Date/Time of Medication Admin. (continued)

Repeated Violation - [redacted] et al.

Plan of Correction ***Accept [redacted] 06/30/2026)***

• Starting 6/14/2026: To ensure ongoing compliance with 187b and avoid further repeats; Executive Director or designee will in-service medication administration staff members on this regulation and the new requirement to conduct assigned POS to MAR to CART to ROOM audits. In-service will address the requirement to initial all administration of medications at the time of administration. Specifically -187b – Review MAR of the 2 POS audits for previous 24 hours. Note any administration times that were not initialed at the time of administration.
• Starting 6/14/2026: Executive Director or designee will assign 10 audits weekly x 10 weeks. Audits will be reviewed during corresponding QA meeting.
• Starting 6/21/2026: RCC will review the audits 3 x week x 10 weeks and report concerns identified to the DHW or designee for immediate action. Results will be reviewed during weekly meeting between RCC and DHW weekly x 10 weeks. Results will be reviewed during corresponding monthly QA meetings x 2 months.
• Starting 6/21/2026: Executive Director or designee will in-service all medication administration staff to this regulation and send 2 weekly reminders through OnShift (employee messaging portal) weekly x 10 weeks.
• Starting 6/21/2026: Executive Director or designee will in-service medication administration staff to the 5/18/2026 LIS violation report to ensure there is department wide understanding of this regulation and how the POS to MAR to CART to ROOM audits are in place to ensure ongoing compliance.
• Week of 6/28/26: Executive Director and Director of Health & Wellness will meet with Staff person A and B individually, review the LIS and the specific violations associated with their actions, documentation of this meeting will be placed in their individual employee files.
• 6/30/2026: POC progress will be reviewed during monthly QA meeting x 2 months.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented [redacted] - 07/20/2026)

187d - Follow Prescriber's Orders

9. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted] Inhale 1 puff by mouth twice daily at 9:00 am and 9:00 pm. However, this medication was not administered to resident [redacted] on [redacted] at 9:00 pm because the medication was not available in the home.

Resident [redacted] is prescribed [redacted] capsule take 2 daily at bedtime. However, this medication was not administered to resident [redacted] on [redacted] because the medication was not available in the home.

187d - Follow Prescriber's Orders (continued)

Resident [redacted] is prescribed [redacted] cream apply to affected area bilateral once daily upon waking. However, this medication was not administered to resident [redacted] on [redacted] because the medication was not available in the home. Resident [redacted] is prescribed [redacted] tablet take 2 tablets by mouth daily. However, this medication was not administered to resident [redacted] on [redacted] because the medication was not available in the home.

Repeated Violation - [redacted]

Plan of Correction ***Accept[redacted] - 06/30/2026)***

• Starting 6/14/2026: To ensure ongoing compliance with 187d and avoid further repeats; medication administration staff members will be in-serviced on this regulation and the new requirement to conduct assigned POS to MAR to CART to ROOM audits. In-service to include when a medication is not available staff must ensure they notify PCP and request instructions; obtain a hold order if appropriate; confirm reorder status of the medication (reorder if needed), notify DHW or ED. Specifically related to this tag the audit includes: 187d -Review MAR of the 2 POS audits for previous 24 hours. Note any meds passed or documented outside of 2-hour window (late or early administration).
• Starting 6/14/2026: The Executive Director or designee will assign 10 audits weekly x 10 weeks. Audits will be reviewed during corresponding QA meeting.
• Starting 6/21/2026: RCC will review the audits weekly x 10 weeks and report concerns identified to the DHW or designee for immediate action. Results will be reviewed during weekly meeting between RCC and DHW weekly x 10 weeks. Results will be reviewed during corresponding monthly QA meetings.
• Starting 6/21/2026: Executive Director or designee will in-service medication administration staff to the 5/18/2026 LIS violation report to ensure there is department wide understanding of this regulation and how the POS to MAR to CART to ROOM audits are in place to ensure ongoing compliance.
• 6/30/2026: POC progress will be reviewed during monthly QA meeting x 2 months.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented [redacted] 07/20/2026)

10. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted], and [redacted] to be administered at 8:00 am. However, resident [redacted] was administered [redacted] and [redacted] on [redacted] at 10:42 am. Resident [redacted] is prescribed [redacted] at 9:00 am. However, resident [redacted] was administered [redacted] at 10:44 am on [redacted] and 11:10 am on [redacted]

Resident [redacted] is prescribed [redacted], and [redacted] at 8:00 am. However, resident [redacted] was administered [redacted] mg, and [redacted] on [redacted] at 10:14 am, [redacted] at 10:24 am, [redacted] at 10:01 am, [redacted] at 11:28 am,

187d - Follow Prescriber's Orders (continued)

and [redacted] at 9:55 am.

Resident [redacted] is prescribed [redacted] at 9:00 am. However, resident [redacted] was administered [redacted] on [redacted] at 11:33 am.

Resident [redacted] is prescribed [redacted] at 8:00 pm. However, resident [redacted] was administered [redacted] mg on [redacted] at 9:13 pm, [redacted] at 9:29 pm, and [redacted] at 10:38 pm.

Repeated Violation - [redacted]

Plan of Correction ***Accept [redacted] - 06/30/2026)***

• Starting 6/14/2026: To ensure ongoing compliance with 187d and avoid further repeats; medication administration staff members will be in-serviced on this regulation and the new requirement to conduct assigned POS to MAR to CART to ROOM audits. In-service to include that all orders must be administered within the regulatory 2-hour timeframe. Specifically related to this tag the audit includes: 187d -Review MAR of the 2 POS audits for previous 24 hours.

• Starting 6/14/2026: The Executive Director or designee will assign 10 audits weekly x 10 weeks. Audits will be reviewed during corresponding QA meeting.

• Starting 6/21/2026: RCC will review the audits weekly x 10 weeks and report concerns identified to the DHW or designee for immediate action. Results will be reviewed during weekly meeting between RCC and DHW weekly x 10 weeks. Results will be reviewed during corresponding monthly QA meetings.

• Starting 6/21/2026: Executive Director or designee will in-service medication administration staff to the 5/18/2026 LIS violation report to ensure there is department wide understanding of this regulation and how the POS to MAR to CART to ROOM audits are in place to ensure ongoing compliance.

• 6/30/2026: POC progress will be reviewed during monthly QA meeting x 2 months.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented [redacted] - 07/20/2026)

251b - Record Entries Legible

11. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted] tablet take 1 twice daily. Resident [redacted] controlled drug administration record for their 9:00 pm administration dated [redacted] was written over without proper notation and illegible.

251b Record Entries Legible (continued)

Plan of Correction ***Accept [redacted] - 06/30/2026)***

• Starting 6/1/2026: Clinical Specialist or designee will conduct an audit of all narcotic logs weekly to ensure compliance with this regulation X 2 months. Audits will be reviewed during corresponding QA meetings x 2 months.
• Starting 6/14/2026: To ensure ongoing compliance with 251b and avoid further repeats; medication administration staff members will be in serviced on this regulation and the new requirement to conduct assigned POS to MAR to CART to ROOM audits. Specifically related to this tag the audit includes: 251b Review Narcotic Log Note the date and initials of staff member who incorrectly "corrected" an error by scribbling through the needed correction instead of drawing a single line through mistake and initialing and confirm the count is correct. Staff to immediately report any discrepancies to the supervisor.
• Starting 6/14/2026: Executive Director or designee will assign 10 audits weekly x 10 weeks. Audits will be reviewed during corresponding QA meeting.
• Starting 6/21/2026: RCC will review the audits weekly x 10 weeks and report concerns identified to the DHW or designee for immediate action. Results will be reviewed during weekly meeting between RCC and DHW weekly x 10 weeks. Results will be reviewed during corresponding monthly QA meetings x 2 months.
• Starting 6/21/2026: Executive Director or designee will in service medication administration staff to the 5/18/2026 LIS violation report to ensure there is department wide understanding of this regulation and how the POS to MAR to CART to ROOM audits are in place to ensure ongoing compliance.
• 6/30/2026: POC progress will be reviewed during monthly QA meeting x 2 months.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented [redacted] - 07/20/2026)