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

May 20, 2026

, ADMINISTRATOR
JOHNSTOWN OPS LLC

RE: RICHLAND WOODS AL
3324 ELTON ROAD
JOHNSTOWN, PA, 15904
LICENSE/COC#: 33834

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/11/2026, 03/12/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *RICHLAND WOODS AL* **License #**: *33834* **License Expiration**: *10/31/2026*

Address: *3324 ELTON ROAD, JOHNSTOWN, PA 15904*

County: *CAMBRIA* **Region**: *CENTRAL*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *JOHNSTOWN OPS LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/14/1999* **Issued By**: *Labor and Industry*

Type: *Other* **Date**: *08/19/1999* **Issued By**: *Richland Township, Cambria County*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *74* **Waking Staff**: *56*

Inspection Information

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

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

Inspection Dates and Department Representative

03/11/2026 - On-Site:

03/12/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* **Residents Served**: *59*

Special Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *59*

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

Have Mobility Need: *15* **Have Physical Disability**: *2*

Inspections / Reviews

03/11/2026 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/10/2026*

Inspections / Reviews *(continued)*

04/13/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/15/2026*

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

04/20/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/15/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/15/2026*

05/20/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/15/2026*

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

18 Other laws, regs, ordins.

1. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

According to the Care Facility Carbon Monoxide Alarm Standards Act, if the Carbon Monoxide (CO) alarm operates by a battery, the battery must be labelled with the date of installation and be replaced at least once annually. On 3/11/26, the carbon monoxide alarms located in the assignment #2 hall on the first floor, on the second floor near living unit #216 and near living unit #215 were operable when tested. However, neither the batteries nor the units were dated indicating when the batteries were last changed.

Plan of Correction ***Accept ([redacted] - 04/20/2026)***

New batteries were installed in the identified CO alarms and clearly labeled with the installation date. All other facility CO alarms were immediately audited and updated to ensure proper battery dating compliances.
The preventative maintenance log within the facility management system was updated to explicitly require the annual replacement of CO alarm batteries and the mandatory labeling of the installation date directly on the battery.
The Environmental Services Manager was trained on the updated policy and the specific requirements of the Carbon Monoxide Alarm Standards Act.
The Executive Director or designee will audit CO alarm battery labels monthly for three months, then quarterly, documenting findings in the preventative maintenance log to support sustained compliance.

On 3/13/26 all batteries were replaced in the CO Monitors within the Community. The Community Environment Services Manager was responsible for completing the initial audit.
The maintenance log was updated on 4/14/26 by the ESM.
On 4/14/26 the Executive Director completed training with the ESM on the Carbon Monoxide Detectors and battery documentation.
The start date for the on-going audits of the CO Monitors is 4/17/26.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/18/2026)

25a Resident - residence contract

2. Requirements

2800.
25.a. Prior to admission, or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident’s designated person if any, prior to signature.

Description of Violation

Resident #1 was admitted to the home on [redacted] However, the resident-residence contract was not signed by the resident until [redacted].

25a Resident - residence contract *(continued)*

Plan of Correction ***Directed (- 04/20/2026)***

Resident #1's contract was verified as signed on An audit of all current resident files was immediately conducted to ensure all resident contracts are fully executed.
The Executive Director will educate Sales Director on the 55 Pa. Code Ch. 2800.25a strict requirement for contract execution prior to or within 24 hours of admission per the Community's Policy.

The ED will be responsible for completing the initial audit.
4/15/26 was educated by the Executive Director on the auditing steps on new admissions.
The ED or SD will complete an audit of the Contact on the day of move in to ensure that all forms are signed on the day of admission but no later than 24 hours after admission.

[Directed]

- *In addition to the above steps, the Executive Director or designee will complete an initial audit of all current resident contracts by 5/15/26. Documentation of this audit will be kept and available for review by the Department.*
- *The Executive Director educated the Sales Director on the 55 Pa. Code Ch. 2800.25a strict requirement for contract execution prior to or within 24 hours of admission per the Community's Policy. This was completed on 4/15/26.*
- *Beginning no later than 5/15/26, the Executive Director or designee will audit the contracts of new admissions within 24 hours of admission to ensure compliance. Documentations of these audits will be kept and available for review by the Department.*

Directed Completion Date: *05/15/2026*

Implemented (- 05/18/2026)

26a Quality management plan

3. Requirements

2800.
26.a. The residence shall establish and implement a quality management plan.

Description of Violation

The residence has a quality management plan that specifies Quality Assurance Improvement Processes (QAIP) meetings are to be held by the 9th of each month. However, the last QAIP meeting was held on 11/7/24.

Plan of Correction ***Accept (- 04/20/2026)***

The QAIP meeting was immediately scheduled and held to address outstanding quality metrics and restore compliance.
The Quality Management Policy was reviewed with the Executive Director and calendar invites created to support scheduling and follow through on monthly quality assurance committee meetings.
The Executive Director and the interdisciplinary QAIP team will be trained by the Regional Director by 5/10/2026 on meeting frequency requirements under 55 Pa. Code 2800.26.a.
The Regional Director will audit QAIP meeting minutes monthly for six months to verify meetings are consistently held by the 9th of each month.

26a Quality management plan (continued)

The QAIP meet was held on 4/7/26 at 1300 by the ED with all of the Directors.
Date that the ED was educated on the QAIP on 4/3/26.
Start date of the on going audit 4/10/26.

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

Implemented (█ - 05/18/2026)

26b Quality management plan content

4. Requirements

2800.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.

Description of Violation

The residence's last quality management review, dated 11/7/24, did not address the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.

Plan of Correction ***Accept (█ - 04/20/2026)***

The Executive Director immediately conducted a supplemental quality management review to specifically evaluate reportable incidents, complaint procedures, and staff training.
The Community's Quality Management Plan (QMP) template was reviewed to verify that mandatory fields for evaluating incident reporting, complaints and staff training were included.
The Executive Director and Leadership Team will be trained on the QAIP template and 55 Pa. Code 2800.26b requirements by May 8th, 2026.
The Regional Director of Operations will audit QMP documentation monthly to verify that all required regulatory elements are consistently evaluated and documented.

QMP template was reviewed by Regional Director of Operation and the Executive Director.
Start date for the on going audits will be 4/10/26.

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

Implemented (█ - 05/18/2026)

63a First Aid/CPR 1:35

6. Requirements

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

Description of Violation

On 2/16/26 from 2:30 PM to 3:00 PM, 59 residents were present in the residence. During this time no staff members were present with certification in the residence who trained in first aid and certified in obstructed airway techniques and CPR.

On 2/16/26 from 3:00 PM to 10:30 PM, 59 residents were present in the residence. During this time only 1 staff member was present in the residence who was trained in first aid and certified in obstructed airway techniques and CPR.

On 2/25/26 from 10:00 PM to 6:30 AM, 59 residents were present in the residence. During this time only 1 staff member was present in the residence who was trained in first aid and certified in obstructed airway techniques and CPR.

On 2/28/26 from 2:00 PM to 10:30 PM, 59 residents were present in the residence. During this time only 1 staff member was present in the residence who was trained in first aid and certified in obstructed airway techniques and CPR.

On 2/28/26 from 10:00 PM to 6:30 AM, 59 residents were present in the residence. During this time only 1 staff member was present in the residence who was trained in first aid and certified in obstructed airway techniques and CPR.

Repeated Violation - 8/27/24, et al

Plan of Correction ***Directed (- 04/20/2026)***

The master schedule was immediately revised to ensure at least two CPR/First Aid certified staff are present on all shifts to accommodate the 59-resident census.
Internal scheduling policies were updated to mandate a daily census-to-certification ratio check prior to publishing schedules and at every shift start.
Schedulers and management were trained on the strict 1:35 certified staff requirement. Uncertified direct care staff were enrolled in expediated CPR/First Aid training.
The Executive Director will audit shift schedules and certification logs weekly for 90 days to verify compliance, reporting results to the QAIP committee.

4/20/26 – The ED is the responsible for updating internal scheduling policies.
5/7/26 – the ED will train the schedulers and management on CPR/First Aid scheduling.
4/14/26 direct care workers were scheduled for a CPR/First Aid class to be held on 4/20/26.
Provide date and persons responsible for training schedulers and management on this requirement
Certification logs and shift schedules will be checked weekly by the ED or designee, starting on 4/20/26.

[Directed]

- *In addition to the above steps, the Executive Director or designee will education the schedulers and management on regulation 2800.63(a) by 5/15/26. Documentation of this education will be kept and available for review by the Department.*

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

- *Beginning no later than 5/15/26, the Executive Director or designee will audit First Aid and CPR certification and shift schedules prior to the schedules being posted to ensure compliance. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: *05/15/2026*

Implemented (- 05/18/2026)

65h 16 hrs annual training

7. Requirements

2800.
65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

Description of Violation

Staff Member A, hired on , received only 12 hours and 10 minutes hours of annual training relating to job duties during the 2025 training year.

Plan of Correction ***Accept (- 04/20/2026)***

Staff Member A immediately completed the remaining 3 hours and 50 minutes of required job-related training to satisfy the 16-hour annual mandate.
The Community implemented a centralized training tracking matrix requiring management to review staff education 90 days prior to each employee's anniversary date.
The Executive Director will educate all department heads on the updated tracking matrix and PA ALR 2800.65h requirements.
The Executive Director will audit all direct care staff training files monthly to ensure continuous compliance with the 16-hour annual requirement.

The ED will be responsible for implementing a centralized training tracking system on 5/7/26
On 5/7/26 all department heads will be educated on centralized training tracking system.
4/20/26 will be the start date for on-going audits.

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

Implemented (- 05/18/2026)

65i Training topics

8. Requirements

2800.
65.i. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
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.

65i Training topics *(continued)*

5. Assisted living service needs of the resident.

Description of Violation

Staff Member A, hired on [redacted] did not receive training in the following training topics during the 2025 training year:
1. Medication self-administration training.
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. Assisted living service needs of the resident.

Plan of Correction ***Accept ([redacted] - 04/20/2026)***

Staff Member A completed the required training modules on medication self-administration, infection control, and assisted living service needs.
The Community implemented automatic tracking through the Learning Management System that alerts management monthly off all direct care staff's annual training completion rates.
The Executive Director trained the Care Team Manager on the tracking system and the requirement for completing all 2800.65i topics.
The Executive Director will audit staff training records monthly for six months to ensure 100% compliance, reporting findings to the Quality Assurance Committee.

Staff member A completed the trainings on 3/31/26.
The ED will be responsible for implementing a centralized training tracking system.
All department heads will be educated on the training tracking system on 5/7/26.
4/20/26 will be the start date for all on-going audits.

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

Implemented ([redacted] - 05/18/2026)

65j Annual training content

9. Requirements

2800.
65.j. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).
5. Falls and accident prevention.

Description of Violation

Staff Member A, hired on [redacted] did not receive training in the following topics during the 2025 training year:
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).

65j Annual training content (continued)

5. Falls and accident prevention.

Plan of Correction ***Accept (█ - 04/20/2026)***

Staff Member A immediately completed the required annual training modules for Resident Rights, OAPSA, and Falls/Accident Prevention.
The Community implemented automatic tracking through the Learning Management System that alerts management monthly off all direct care staff's annual training completion rates.
The Executive Director will educate all staff on mandatory state annual training requirements and the updated tracking system.
The Executive Director or designee will audit the staff training matrix monthly to ensure 100% ongoing compliance, reporting results to the QAIP Committee.

The ED will be responsible for implementing a centralized training tracking system on 5/7/26.
All department heads will be educated on the training tracking system on 5/7/26.
4/20/26 will be the start date for all on going audits.

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

Implemented (█ - 05/18/2026)

81b Resident equip – good repair

10. Requirements

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

Description of Violation

On 3/11/26, Resident #2's bedside mobility device was not properly covered. The cover on the bedside mobility device is only covering the left side of the device, affixed with a clip which easily disconnects from the device. The right side of the cover is not clipped, creating an opening which is 16.75 inches wide and 6 inches long, posing an entrapment risk.

Plan of Correction ***Accept (█ - 04/20/2026)***

Resident #2's bedside mobility device was immediately removed. A Community wide audit of all resident mobility devices was conducted to ensure no other hazards existed.
The Community's Bed Mobility Device policy was reviewed to verify mandatory entrapment risk assessments and cover installation protocols for all bedside mobility apparatuses prior to resident use are required. Care plans were reviewed to verify that daily checks of all bed mobility devices are in place.
The Executive Director and Environmental Services Manager will train the care team on proper device installation, inspection, and entrapment hazard identification by 4/30/2026.

81b Resident equip – good repair (continued)

The Environmental Services Manager or designee will conduct weekly audits of 100% of resident mobility devices to ensure they remain in good repair and free from hazards for 90 days.

The ESM removed Resident #2's mobility device on 4/3/26
The ESM completed the audit on mobility devices within the community on 4/15/26.
On 4/15/26 ED and ESM reviewed policy and care plans.
The start date for the on-going audits is 4/15/26.

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

Implemented (█ - 05/18/2026)

101n Walls, floors & ceilings

11. Requirements

2800.
101.n. The living unit must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On 3/11/26, the carpet in the living room and bedroom of living unit #111 had multiple stains ranging from 1/2 inch and 2 inches wide and were brown, dark brown and gray in color.

Plan of Correction ***Accept (█ - 04/20/2026)***

The carpet in living unit #111 is scheduled to be replaced on 4/16/26.
Housekeeping team will be trained to documented floor inspections during weekly room cleanings to schedule prompt treatment of stains.
Housekeeping and care team will be trained by the Executive Director on the updated floor inspection and immediate stain reporting protocols by April 24, 2026.
The Executive Director or designee will audit five random resident rooms weekly for three months to verify carpet cleanliness and proper floor condition.

The on-going audits will start on 4/20/26.

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

Implemented (█ - 05/18/2026)

107c Food/water – 3 day supply

12. Requirements

2800.
107.c. The residence shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 3/12/26, the residence served 59 residents, requiring 177 gallons of emergency drinking water. However, the residence had only 174 gallons. The residence does not have a contract with a local bottled water supplier that

107c Food/water – 3 day supply (continued)

includes emergency delivery of drinking water.

Plan of Correction ***Accept (- 04/20/2026)***

The Community immediately purchased additional bottled water to exceed the 177 gallon requirement based on the current census of 59 residents.
The Community contracted a local water supplier for emergency deliveries and revised the Emergency Preparedness Plan to include weekly water inventory checks based on census data.
The Executive Director will train Culinary, Environmental Services and the Care Team by 5/1/26 on the PA 2800.107c regulation requiring 1 gallon of water per resident per day for 3 days.
The Executive Director or designee will audit the emergency water inventory against the current resident census monthly, reporting compliance to the QAIP Committee.

. was contracted to supply water to the community on 10/30/17.
On 4/9/26 the ED updated the Emergency Preparedness Plan.
The ongoing audits will start on 4/21/26.

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

Implemented (- 05/18/2026)

125b Combustible res. access

13. Requirements

2800.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On 3/11/26 at 9:13 AM, a 5 gallon gas container filled with gasoline was unlocked, unattended, and accessible to residents in the patio area, sitting on top of a storage bin located near a snow blower.

Plan of Correction ***Accept (- 04/20/2026)***

The 5 gallon gasoline container was immediately removed from the patio and secured in a locked, resident inaccessible maintenance shed.
The Community's chemical management policies were reviewed to ensure that all flammable fuels and chemicals are locked immediately after active use.
All maintenance and community staff will complete required education on PA ALR 2800.125b by May 1, 2026.
The Executive Director or designee will conduct weekly environmental audits of all outdoor and storage areas to ensure combustible materials remain fully secured.

The ESM removed the gasoline container on 3/11/26.
The on going audits started on 4/14/26.

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

125b Combustible res. access *(continued)*

Implemented (- 05/18/2026)

132c Fire drill records

14. Requirements

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

Description of Violation

The fire drill record for the drill conducted on 11/14/24 does not include how many residents were in the home.

The fire drill record for the drill conducted on 12/17/24 does not include how many residents were in the home and how many residents evacuated the home.

Plan of Correction ***Accept (- 04/20/2026)***

The fire drill records for 11/14/24 and 12/17/24 were immediately corrected to reflect the accurate number of residents present and evacuated.
The Community's standard Fire Drill Record form was revised and placed in the building management system to prominently highlight resident census and total evacuated as mandatory fields.
The Environmental Services Manager and all leaders were trained on the revised form and 55 Pa. Code § 2800.132c documentation requirements.
The Executive Director will audit all fire drill records within 24 hours of each drill for the next six months to verify 100% completion of all required fields.

The ED is responsible for correcting the fire drill logs.
The ED is responsible for revising the homes standard fire drill record form, starting on 4/20/26.
On 5/7/26 the ESM and all leaders were educated on the fire drills.
The on-going audits will start for the next fire drill on 4/21/26.

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

Implemented (- 05/20/2026)

141b1 Annual medical evaluation

15. Requirements

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

Description of Violation

Resident #1's most recent medical evaluation, dated does not include the height of the resident.

141b1 Annual medical evaluation (continued)

Resident #3's most recent medical evaluation, dated [redacted], does not include the height of the resident.

Resident #4's most recent medical evaluation, dated [redacted] does not include the height of the resident.

Plan of Correction ***Accept ([redacted] - 04/20/2026)***

Heights for Residents #1, #3, and #4 were immediately measured, documented, and submitted to their respective physicians to amend the medical evaluations.
The Community implemented a Medical Evaluation QA Checklist requiring clinical staff to verify all mandatory fields, specifically height, prior to accepting the form.
The Health and Wellness Director will train all clinical and administrative staff by 2026-05-08 on utilizing the new QA Checklist to ensure complete regulatory compliance.
The Executive Director will audit 100% of incoming medical evaluations weekly for four weeks, then 10 random files monthly for three months to ensure sustained compliance.

The Area Director of Clinical Operations ADCS was responsible for updating Resident's 1, 3, and 4's DME's.
On 4/20/26 the HWD is responsible for implementing Medical Evaluation Checklist.
Initial audit of all current annual DMES to ensure compliance will be completed by 4/30/26 by the HWD.
On-going audits will start on 4/30/26.

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

Implemented ([redacted] - 05/20/2026)

144c2 Smoking area distance

17. Requirements

2800.
144.c. A residence that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The residence's designated smoking area near the main entrance of the home is located along a common walkway.

Plan of Correction ***Accept ([redacted] - 04/20/2026)***

The designated smoking area was immediately relocated to a safe, compliant exterior area away from the main entrance, exits, and all common walkways.
The Community's written Fire Safety Policy was updated to specify and enforce the newly mapped, compliant smoking location.
All staff and residents will be educated on the updated smoking policy and the exact location of the newly designated smoking area.
The Executive Director or designee will conduct weekly audits of the exterior premises for 12 weeks to verify adherence to the designated smoking area.

144c2 Smoking area distance (continued)

The Fire Safety policy was updated on 4/15/26 by the ED.
Staff and Resident education will take place on 5/7/26.
On-going audits will start on 4/20/26.

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

Implemented (█ - 05/20/2026)

183d Current medications

18. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 3/12/26, Tylenol prescribed for Resident # 4, was in the residence's medication cart; however, there was not a current order for this medication.

Plan of Correction ***Accept (█ - 04/20/2026)***

Resident #4's unprescribed Tylenol was immediately removed from the medication cart and properly destroyed per community protocol.
The Medication Storage Policy was reviewed with nursing staff to educate on mandatory reconciliation of physically stored medications against active orders during monthly cart changeovers.
The Health and Wellness Director will conduct weekly random medication cart audits for four weeks, then monthly thereafter to ensure only actively prescribed medications are stored.

Community RN removed Resident 4's Tylenol from the med cart.
The ADCS did the education on the staff on 4/13/26.
The start date for on-going audits is 4/6/26.

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

Implemented (█ - 05/20/2026)

184b - Labeling OTC/CAM

19. Requirements

2800.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 3/12/26, a package of magnesium capsules belonging to Resident #5 was in the medication cart and was not labeled with the resident's name.

Plan of Correction ***Accept (█ - 04/20/2026)***

Resident #5's magnesium capsules were immediately labeled with their name. All medication carts were audited to ensure all resident-owned OTC medications and CAMs are properly labeled.
The Medication Management was reviewed with staff to educate on the requirement for staff to immediately label all resident-owned OTC medications and CAMs upon receipt into the facility.

184b - Labeling OTC/CAM (continued)

All med passers and nursing staff will be educated on 55 Pa. Code § 2800.184b and the updated OTC labeling policy by 05/08/2026.
The Health and Wellness Director or designee will audit all medication carts weekly for four weeks, then monthly for three months, to verify consistent OTC labeling compliance.

The Community RN was responsible for labeling Resident #5 magnesium capsule.
The ADCS did the education on the staff on 4/13/26.
The start date for on-going audits is 4/6/26.

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

Implemented (- 05/20/2026)