

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

May 4, 2026

[REDACTED]  
PETER BECKER COMMUNITY

[REDACTED]  
ATTN:DIRECTOR OF PERSONAL CARE  
[REDACTED]

RE: PETER BECKER COMMUNITY  
800 MAPLE AVENUE, 1ST FLOOR  
HARLEYSVILLE, PA, 19438  
LICENSE/COC#: 12773

[REDACTED],

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

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

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

**Name:** PETER BECKER COMMUNITY      **License #:** 12773      **License Expiration:** 06/09/2026

**Address:** 800 MAPLE AVENUE, 1ST FLOOR, HARLEYSVILLE, PA 19438

**County:** MONTGOMERY      **Region:** SOUTHEAST

**Administrator**

**Name:** [REDACTED]      **Phone:** [REDACTED]      **Email:** [REDACTED]

**Legal Entity**

**Name:** PETER BECKER COMMUNITY

**Address:** [REDACTED]

**Phone:** [REDACTED]      **Email:** [REDACTED]

**Certificate(s) of Occupancy**

Type: I-1	Date: 08/15/2012	Issued By: Township of Franconia
Type: I-2	Date: 08/15/2012	Issued By: Township of Franconia
Type: Other	Date: 08/15/2012	Issued By: Township of Franconia

**Staffing Hours**

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

**Inspection Information**

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

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

**Inspection Dates and Department Representative**

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

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 68      **Residents Served:** 55

**Secured Dementia Care Unit**

**In Home:** Yes      **Area:** Larkspur      **Capacity:** 11      **Residents Served:** 9

**Hospice**

**Current Residents:** 0

**Number of Residents Who:**

Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 55
Diagnosed with Mental Illness: 1	Diagnosed with Intellectual Disability: 0
Have Mobility Need: 19	Have Physical Disability: 0

**Inspections / Reviews**

03/12/2026 Partial

**Lead Inspector:** [REDACTED]      **Follow-Up Type:** POC Submission      **Follow-Up Date:** 04/19/2026

Inspections / Reviews *(continued)*

04/17/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/30/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/01/2026

05/04/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/30/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

16d Final Incident Report

1. Requirements

2600.

16.d. The home shall submit a final report, on a form prescribed by the Department, to the Department's personal care home regional office immediately following the conclusion of the investigation.

Description of Violation

On [redacted] at 10:00 pm, staff person A and staff person B were assisting resident [redacted] with transferring to [redacted] wheelchair when the resident lunged forward onto [redacted] knees. Resident [redacted] became incoherent and the resident's speech also became slurred. The resident was transported to the hospital via ambulance. The home submitted an initial incident report on [redacted] The home did not submit a final report to the Department.

Plan of Correction

Accepted [redacted] 04/17/2026

Final Incident Report for the 2/17/26 has been submitted to DHS as of 4/12/26. Copy attached.

PCHA will audit all incident reports submitted since last Full Inspection (August 2025) by 4/30/26 to ensure that final reports have been submitted on all incidents. If reports have not been submitted, all reports will be submitted by 5/1/26.

PCHA or designee will audit all incident reports monthly for a period of no less than 3 months (longer if non-compliance is found) to ensure that a final report is filed upon completion of investigation and/or resolution of the incident.

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

Implemented [redacted] - 05/04/2026

17 Record Confidentiality

2. Requirements

2600.

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

Description of Violation

On [redacted], at approximately 9:59 am, at Primrose Path, the medication room was unlocked, unattended, and accessible, with a controlled substance binder on top of the desk.

Repeat Violation: [redacted], et al.

Plan of Correction

Accepted [redacted] - 04/17/2026

All Personal Care staff will receive an updated training on maintaining record and protected information confidentiality by 4/30/26 - or their next shift worked if after 4/30/26 for prn and seasonal employees (copy of training outline attached).

PCHA or designee will complete random spot checks weekly for a period of no less than 3 months (longer if non-compliance is found) to ensure that the med rooms are locked when there is not a staff member present, to ensure

17 Record Confidentiality (continued)

that the controlled substance binders (or any other medical/resident protected information) are not in view or accessible to anyone not covered under the regulation.

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented [redacted] 05/04/2026)

18 - Compliance With Laws

3. Requirements

2600.

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

Description of Violation

Personal Care Homes and Assisted Living Residences must post the required influenza information in a public place in the home year round as required by the Influenza Awareness Act (HB 1785). On [redacted] the home did not have an influenza poster anywhere.

Plan of Correction

Accept [redacted] - 04/17/2026)

Influenza awareness posters were received from DHS surveyor on 3/13/26 and were immediately posted in Personal Care areas.

PCHA or designee will complete random spot checks weekly for a period of no less than 3 months (longer if non compliance is found) to ensure that flu posters remain posted as required.

Licensee's Proposed Overall Completion Date: 04/12/2026

Implemented [redacted] - 05/04/2026)

41c - Rights Poster

4. Requirements

2600.

41.c. The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the home.

Description of Violation

The Department's resident's rights poster is not posted in a conspicuous and public place in the secured dementia care unit.

Plan of Correction

Accept [redacted] - 04/17/2026)

Resident Rights were posted in the secure dementia care unit on 3/13/26.

PCHA or designee will complete random spot checks weekly for a period of no less than 3 months (longer if non compliance is found) to ensure that resident rights posters remain posted as required

## 41c - Rights Poster (continued)

Licensee's Proposed Overall Completion Date: 04/12/2026

Implemented [REDACTED] - 05/04/2026)

## 42b - Abuse

## 5. Requirements

2600.

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

**Description of Violation**

On [REDACTED] resident [REDACTED] was admitted to St. Lukes Grand View Hospital following an unwitnessed fall. Resident [REDACTED] had an unwitnessed fall and hit their head. Resident [REDACTED] reported tripping on [REDACTED] pajamas while trying to go to the bathroom. Resident [REDACTED] remained on the floor for an unknown duration of time and used [REDACTED] shoe to hit [REDACTED] bedroom door to alert staff. At 3:15 am, staff person C found the resident and assisted the resident in sitting on [REDACTED] chair and administered [REDACTED]. Resident complained of head and gluteal pain. Resident [REDACTED] is prescribed [REDACTED] for chronic anticoagulation. Medical documentation revealed findings of bruising on [REDACTED] and left [REDACTED] and [REDACTED] on [REDACTED] head.

Resident [REDACTED]'s assessment and support plan (RASP), dated [REDACTED] indicates the resident requires physical assistance with transfers in and out of bed and chair and toileting assistance needed daily with ambulation to the bathroom and management of incontinence products.

The home's internal investigation determined that the resident requested to be sent to the hospital; however, staff person C responded that the resident was administered [REDACTED] and was not sure if the resident should be sent to the hospital.

Resident [REDACTED] family member reported receiving calls from the home at 4:12 am, 4:40 am, 4:46 am, and 4:54 am. Resident's family disclosed speaking to the resident between approximately 4:12 am and 4:54 am. The resident informed the family member that [REDACTED] fell in [REDACTED] bedroom and hit [REDACTED] head. The resident informed the family member that they requested a hospital evaluation, however staff did not respond to the request. Resident [REDACTED] family member indicated that a staff member entered the resident's room while they were on the phone and the family advised that the resident should be evaluated at the hospital due to anticoagulated use. Family member reported that 911 was called at 5:10 am. Medical documentation confirms the resident began to receive care at St. Luke's Grand View Hospital at 6:18 am.

Resident [REDACTED] was admitted on [REDACTED] to personal care with a wander guard pending placement in the secured dementia care unit. Resident [REDACTED] has removed their wander guard on 5 different occasions. The resident has a history of exit seeking. On [REDACTED] at approximately 2:11 pm, the resident was observed walking outside and behind the Primrose Path sunroom. Staff person B redirected the resident back into the home. Resident [REDACTED] did not have [REDACTED] wander guard on [REDACTED] wrist, which was documented at 10:00 am as being present. On [REDACTED] a staff person from skilled unit, brought the resident back to Primrose Path after the resident exited through the doors before lunch.

Resident [REDACTED] initial resident assessment and support plan (RASP) dated [REDACTED], states the resident requires moderate supervision. The resident needs assistance and supervision in the home regularly and requires assistance when in unfamiliar places. Resident [REDACTED]'s staff and family will accompany the resident on any outside outings. With a

**42b - Abuse (continued)**

wander guard in place, staff should follow the resident to take walks within the building. Orientation to time, place, and person is indicated as a severe problem. Resident [REDACTED] is oriented towards himself and is known to wander and not know how to get back home. Resident [REDACTED] has a wander guard in place due to elopement risk and placement is checked daily.

On [REDACTED], hourly checks were put into place for the resident's safety due to staff being unable to locate the resident's wander guard that [REDACTED] removed. Resident [REDACTED]'s hourly checks on [REDACTED] at 10:00 pm were not documented as completed. Resident [REDACTED]'s hourly checks on [REDACTED] at 1:00 pm and 2:00 pm were not documented as completed. Resident [REDACTED]'s hourly checks on [REDACTED] from 12:00 am to 6:00 am [REDACTED] were not documented as completed.

On [REDACTED], approximately 10:45 am, resident [REDACTED] exited the home through the Primrose Path sunroom exit door. Resident [REDACTED] was observed walking in the hallway towards the sunroom by staff person D. Staff person D followed to check on the resident and observed that the resident exited the home and was holding the door shut to prevent staff from following [REDACTED]. Staff person B asked the resident to open the door for the staff person to be able to get home to [REDACTED] children. Resident [REDACTED] released the door and walked towards the parking lot and walked onto the street on [REDACTED] onto traffic, ambulating with [REDACTED] cane. The speed limit on [REDACTED] is 35 mph, and the speed limit in the parking lot is 15 mph. Staff person B and staff person D followed the resident. Resident [REDACTED] was swinging [REDACTED] cane at them, threatening to harm them. Staff person B redirected the resident to the sidewalk after [REDACTED] refused.

Staff person E was also asked to assist with the resident because they have a good relationship. Staff reported that the resident was wearing pajama pants, sneakers and a fleece jacket. Staff reported that the resident stated [REDACTED] plan was to take a flight back to [REDACTED]. The outside temperature was approximately 32 Fahrenheit and weather conditions were described as cold. It took approximately 30 minutes for staff person B, staff person D and staff person E to successfully redirect the resident back into the home. Staff disclosed that resident [REDACTED] was making statements that [REDACTED] wanted to die while walking back to the home. Resident [REDACTED] was assessed and did not sustain any injuries. Staff disclosed that the resident's family reported that while [REDACTED] was eating lunch, [REDACTED] slid the butterknife across [REDACTED] wrist. Resident [REDACTED] was transported to Chestnut Hill Hospital on [REDACTED].

**Plan of Correction**

Accept [REDACTED] - 04/17/2026)

Resident [REDACTED] - All PC staff (with the exception of one on medical leave and prn/seasonal) were trained by 3/2/26 on the updated falls protocol. Additionally, all new hires are being trained during their first 40 hours of training. A binder was created and placed in each Personal Care neighborhood for all new and/or updated protocols for easy reference for all staff as well. Resident 1 has since been discharged from PC to SNF for LTC due to the need for greater medical oversight.

Resident [REDACTED] - resident was a CCRC residential living resident prior to [REDACTED] admission to SNF and then PC due to increased confusion and wandering in residential living. The extent of [REDACTED] Mental Health diagnoses were not known to any staff at PBC prior to this admission. Shortly after admission, resident was referred to/seen by CRNP who adjusted medications due to behaviors and failure of any other positive interventions (redirection, attempts to engage in community activities, assistance sought from family, providing favorite foods). As resident continued to remove wanderguards and behaviors/delusions increased, and upon [REDACTED] last elopement and apparent onset of suicidal ideation, resident was transported and admitted to geri-psych unit at Chestnut Hill Hospital in an attempt to stabilize [REDACTED]. Upon discharge from CHH Geri-Psych family elected to have resident transferred to a different facility that had openings in a Secure unit. There are no other residents in PC with significant psychiatric disorders or

42b - Abuse (continued)

behaviors. Additional trainings for interventions will be provided to staff if any admissions of residents with these disorders are planned in the future.

Licensee's Proposed Overall Completion Date: 04/16/2026

Implemented ( [REDACTED] 05/04/2026)

44g - Telephone Number

6. Requirements

2600.

44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone numbers of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP) the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline is not posted in a conspicuous and public place in the secured dementia care unit.

Plan of Correction

Accept ( [REDACTED] 04/17/2026)

Telephone number poster was posted in the secure dementia care unit on 3/13/26.

PCHA or designee will complete random spot checks weekly for a period of no less than 3 months (longer if non-compliance is found) to ensure that the telephone numbers remain posted as required

Licensee's Proposed Overall Completion Date: 04/12/2026

Implemented ( [REDACTED] 05/04/2026)

65g - Annual Training Content

7. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person D did not receive training in Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite

65g - Annual Training Content (continued)

staff person trained by a fire safety expert during training year [REDACTED]

Repeat Violation: [REDACTED], et al.

Plan of Correction

Accept [REDACTED] - 04/17/2026

As a result of annual survey completed in August 2025, all PC staff (including staff person D) received in person annual fire safety training from a staff person trained by a fire safety expert in October 2025. Documents attached.

All new hires since that inspection have received in-person fire safety on their first day as part of company wide orientation (or individually if not able to attend the company wide orientation prior to their first day of work in their role.

Peter Becker's annual training period runs from 7/1-6/30 of each year. As of today all current Personal Care employees have received in person fire safety for the training year 7/1/25-6/30/26.

Licensee's Proposed Overall Completion Date: 04/12/2026

Implemented [REDACTED] - 05/04/2026

82c - Locking Poisonous Materials

8. 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

Hillyard hand soap, with a manufacture's label indicating "in case of accidental ingestion, seek medical attention or contact a poison control center immediately", was unlocked, unattended, and accessible to residents in Larkspur memory care activity room on the sink. Not all the residents at Larkspur have been assessed capable of recognizing and using poisons safely.

Repeat Violation: [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 04/17/2026

All activities staff will receive in-service training on poisonous materials by 4/30/26. Additionally, random weekly audits will be conducted by PCHA or designee to ensure compliance in all areas of the SDCU for a period of 3 months (or longer if non-compliance is found).

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented [REDACTED] - 05/04/2026

141a - Medical Evaluation

9. 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.

141a Medical Evaluation (continued)

Description of Violation

Resident [redacted] was admitted on [redacted]. The medical evaluation was not completed within 60 days prior to admission or within 30 days after the admission of the resident.

Plan of Correction

Accept [redacted] - 04/17/2026)

Resident [redacted] has been discharged from Personal Care.

PCHA has completed an audit of all current residents and determined that all current residents have an admission DME form completed.

PCHA or designee will complete monthly audits of all new admissions for a period of 3 months (or longer if non compliance found) to ensure that all new admissions have a DME form completed within the regulatory timelines.

Admission requirements have been updated to include that any residents being admitted to PC from Peter Becker Skilled Nursing will have a DME completed by the onsite CRNP prior to transfer to PC. Residents being admitted from the community at large will be required to have a DME completed prior to admission if they are not currently and/or will not be switching to the primary care provider on site.

Licensee's Proposed Overall Completion Date: 04/12/2026

Implemented [redacted] - 05/04/2026)

183b - Meds and Syringes Locked

10. 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 9:59 am, the medication room refrigerator was unlocked, unattended, and accessible in Primrose Path.

Plan of Correction

Accept [redacted] 04/17/2026)

All staff will receive in service training on this regulation by 4/30/26 or their next shift worked if after that date (primarily PRN or seasonal staff).

PCHA or designee will complete random spot checks weekly for a period of no less than 3 months (longer if non compliance is found) to ensure that the med rooms are locked when there is not a staff member present.

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented [redacted] - 05/04/2026)

187c - Refusal of Medication

11. Requirements

2600.

187c - Refusal of Medication (continued)

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On [redacted] and [redacted] resident [redacted] refused to take a scheduled dose of [redacted] at 6:00 am. The home did not document the refusal on the resident's medication administration record.

Plan of Correction

Accept ( [redacted] - 04/17/2026)

All Medication Technicians will receive in-service training on this regulation by 4/30/26 or their next shift worked if after that date (primarily PRN or seasonal staff).

Medication Tech trainer will complete monthly audits for a period of no less than 3 months (longer if non-compliance is found) to ensure that any medication refusals are being documented appropriate in the eMar and that all physician notifications are occurring as indicated on the Prescriber Notification Preference Form

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented ( [redacted] - 05/04/2026)

201 - Positive Interventions

12. Requirements

2600.

201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident [redacted] has exit-seeking behaviors. Resident [redacted] was admitted to the home on [redacted] [redacted] has removed their wander guard on 5 different occasions. On [redacted] at approximately 2:11 pm, the resident was observed walking outside and behind the Primrose Path sunroom. On [redacted], a staff person from skilled care brought the resident back to Primrose Path after resident [redacted] exited through the doors before lunch. On [redacted] the resident removed the wander guard, exited the home and walked towards the home's parking lot and the street on Yoder Road. The home has not implemented positive interventions to modify or eliminate the behavior.

Plan of Correction

Accept ( [redacted] 04/17/2026)

Staff made multiple attempts to engage resident in community activities and reached out to family for assistance in discovering preferences without success. Wanderguards were placed and removed (unknown mechanism for removal until a large nail clipper was located at discharge). Resident was referred to PCP and Psych CRNP for assessment and medication changes when behaviors escalated and ultimately was transferred to Geri-Psych unit at Chestnut Hill Hospital on the day resident eloped and manifested Suicidal Ideation with the hope that intensive therapy and treatment would stabilize resident prior to return.

Resident's family elected to transfer [redacted] to another community due to PBC not having any availability in our SDCU. Resident has been discharged from PBC as of 3/19/26.

All staff were previously trained on Safe Management Techniques and this is a part of the annual training plan. Should there be any future admissions of residents with significant mental health diagnoses, all staff will receive training specific to those disorders.

201 Positive Interventions (continued)

Licensee's Proposed Overall Completion Date: 04/16/2026

Implemented [REDACTED] - 05/04/2026)

225c - Additional Assessment

13. 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

Resident [REDACTED] most recent assessment was completed on [REDACTED]. Resident [REDACTED] had a fall on [REDACTED], [REDACTED], and [REDACTED]. An assessment to address the resident's change of condition was not completed.

Plan of Correction

Accept ([REDACTED] 04/17/2026)

Resident [REDACTED] was admitted to personal care on 1/22/26 from skilled nursing due to [REDACTED] recent history of multiple falls while in [REDACTED] independent living setting. Resident 1 discharged from PC to SNF after ER visit on 2/17/26 due to care needs exceeding PC ability.

PC Staff will receive an updated in service training regarding Assessments/Support Plans by 4/30/26 or their next shift worked if after that date (prn and seasonal staff).

PCHA/LPNs will meet at least weekly to review all residents to ensure that all assessment/support plans are being completed in a timely manner to maintain regulatory compliance

Licensee's Proposed Overall Completion Date: 04/30/2026

Implemented [REDACTED] - 05/04/2026)

227d - Support Plan Medical/Dental

14. 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] does not indicate the behavioral or cognitive need and degree for aggression, hallucinations, communication of needs, understanding instructions, short term memory, long term memory and ability to use or avoid poisonous materials.

The assessment for resident [REDACTED] dated [REDACTED], does not indicate the frequency on the resident's aggression

227d - Support Plan Medical/Dental (continued)

behavioral need and does not indicate the behavioral or cognitive need and degree for agitation.

Repeat Violation: [REDACTED]

Plan of Correction

Accept [REDACTED] 04/17/2026)

Resident [REDACTED] has been discharged from PC to SNF for LTC. Resident [REDACTED] was discharged from PC/Facility due to recommendation for a secure setting and none being available in our community.

PCHA/Designee will audit all assessment/support plans for current residents and correct any missing information by 4/30/26. Going forward, PCHA/Designee will review all assessment/support plans (initial, annual and significant change) for a period of at least 3 months (longer if non-compliance found)

Licensee's Proposed Overall Completion Date: 04/13/2026

Implemented [REDACTED] - 05/04/2026)

251b - Record Entries Legible

15. 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

Correction fluid was used on resident's [REDACTED]'s contract dated 2/5/2026.

Plan of Correction

Accept [REDACTED] - 04/17/2026)

As a result of this inspection and deficiency, PCHA and all staff are now aware that white out/correction fluid may not be used on any items in resident records.

PCHA will audit all new contracts and other paper documents to be entered into resident record for a period of 3 months (longer if non-compliance found) to ensure proper completion of paperwork.

Licensee's Proposed Overall Completion Date: 04/13/2026

Implemented [REDACTED] 05/04/2026)