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

May 4, 2026

[redacted]
LANDINGS OPCO1, LLC
[redacted]

RE: MORNINGSIDE HOUSE OF COLLEGEVILLE
1421 SOUTH COLLEGEVILLE ROAD
COLLEGEVILLE, PA, 19426
LICENSE/COC#: 15106

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/16/2026, 03/17/2026 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: *MORNINGSIDE HOUSE OF COLLEGEVILLE* **License #**: *15106* **License Expiration**: *03/05/2027*

Address: *1421 SOUTH COLLEGEVILLE ROAD, COLLEGEVILLE, PA 19426*

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

Administrator

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

Legal Entity

Name: *LANDINGS OPCO1, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *06/30/2016* **Issued By**: *Upper Providence Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *145* **Waking Staff**: *109*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *03/17/2026*

Inspection Dates and Department Representative

03/16/2026 - On-Site: [redacted]

03/17/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *110* **Residents Served**: *95*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Legacy House* **Capacity**: *35* **Residents Served**: *29*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *95*

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

Have Mobility Need: *50* **Have Physical Disability**: *5*

Inspections / Reviews

03/16/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/09/2026*

04/14/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/28/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/17/2026*

Inspections / Reviews *(continued)*

04/15/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/28/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/04/2026*

05/04/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/28/2026*

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

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On [redacted] from 7:00 PM to 11:00 PM, 95 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On [redacted], from 7:00 PM to 11:00 PM, 95 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On [redacted], from 11:00 PM to 7:00 AM, 95 residents were present in the home. During this time no staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On [redacted] from 7:00 PM to 11:00 PM, 95 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On [redacted] from 7:00 PM to 11:00 PM, 95 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

Plan of Correction ***Accept ([redacted] - 04/14/2026)***

The Employee Relations and Administration Coordinator audited the employee files by 3/20/26. Upon identification of staffing with online CPR training, the schedule was reviewed by the Wellness Coordinator to ensure a minimum of two staff members certified in First Aid, CPR, and obstructed airway techniques were present in the building at all times based on the census requirement on 3/20/26. Any gaps in coverage were immediately corrected.

New employees and current employees with online certification were enrolled in an in-person CPR/First Aid certification course on 4/2/26. Education was provided to the Employee Relations and Administration Coordinator (ERAC) by the Executive Director that online courses cannot be accepted on 3/17/26. The ERAC will provide the Wellness Coordinator with the updated list of employees with certifications monthly, so the Wellness Coordinator can ensure the schedule is within compliance.

Going forward the ERAC will complete an annual audit on the employee files to ensure accuracy of the list of CPR certifications. The Director of Health and Wellness or designee will audit the schedule once a week for three months to ensure it remains in compliance.

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

Implemented [redacted] - 05/04/2026)

65g - Annual Training Content

2. 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:

65g Annual Training Content *(continued)*

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 A 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 staff person trained by a fire safety expert during training year [redacted] to [redacted].

Plan of Correction ***Accept [redacted] 04/14/2026)***

Staff Person A immediately reviewed fire safety training with Plant Ops Director who has been certified as a qualified trainer. Plant Ops Director scheduled full Fire Safety Training for all staff for 4/30/26.

The Employee Relations & Admin Coordinator (ERAC) did a full audit of 2025 trainings by 3/20/26 to ensure all required education components were present and documented.

Going forward, the ERAC will review training compliance monthly for three months then quarterly thereafter. ERAC will notify Directors if employees missed a monthly training, Directors will work with their staff to get their needed training through Relias, Executive Director or designee to stay within the annual training requirements.

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

Implemented [redacted] - 05/04/2026)

81b - Resident Personal Equipment

3. 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

On [redacted] resident [redacted] had an oval shaped bed cane with a gap in the bar of 8 inches at the bottom of the device that lined up with the top of the mattress. The device was securely attached to the bed however, the oval opening in the device measured 15 inches wide by 8.5 inches high creating an entrapment zone. The device was covered with an unsecured loose pillowcase which is not the correct cover for the device.

Plan of Correction ***Accept [redacted] - 04/14/2026)***

Resident [redacted] bed cane was immediately removed. Resident [redacted] spouse was notified by Memory Care Director and spouse informed [redacted] that the cover was taken home. Spouse brought in the cover, bed cane reinstalled in accordance with manufacturer guidelines 3/23/26. Therapy assessed resident for safety and mobility needs 3/23/26.

Director of Health and Wellness did a full audit of all bed enabler devices to ensure that all equipment is safe, properly installed, free of hazards, and within compliance by 3/23/26.

81b Resident Personal Equipment (continued)

Going forward, Director of Health and Wellness, Maintenance Director, or designee will complete monthly environmental safety rounds to include resident equipment inspections for three months, then quarterly thereafter.

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

Implemented [redacted] - 05/04/2026)

82c - Locking Poisonous Materials

4. 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

On [redacted] a bottle of Gojo foam hand cleaner, with a manufacture's label indicating "If swallowed consult a physician or poison control", was unlocked, unattended, and accessible to residents in room[redacted] not all the residents of the home, including resident [redacted], have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 04/15/2026)***

Director of Plant Ops immediately removed the hand cleaner.

Memory Care Director audited all resident rooms to ensure all rooms were free of hazardous or poisonous materials on 3/17/26.

All staff re educated on locking poisonous materials/chemicals in a secured memory care unit on 3/26/26 by Executive Director.

Memory Care Director or designee will complete a weekly audit for three months to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/14/2026*

Implemented [redacted] 05/04/2026)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On [redacted] at 8:20 AM the 1st floor medication cart had a white powdery dust present next to the pill crusher. Staff person B pulled out medications for resident[redacted] and placed them on top of the cart and powder. Staff person B failed to wash hands or use hand sanitizer prior to pulling out medications from the cart and administering medication to resident [redacted]

On [redacted] at 11:00 AM and 12:50 PM the floor to the right in the in the memory care area had a substance on it causing shoes to stick to the floor while walking.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept [redacted] - 04/14/2026)***

The medication carts were immediately wiped down upon notification by Wellness Coordinator. Director of Health and Wellness immediately re-educated Staff person B regarding competency on hand hygiene, medication cart sanitation, and infection prevention. Housekeeping immediately mopped the memory care area.

Director of Health and Wellness completed re-education to all certified Med Techs competency on hand hygiene, medication cart sanitation, and infection prevention on 3/26/26. Plant Ops Director reviewed rounding and spot cleaning procedures with housekeeping on 3/16/26.

Director of Health and Wellness or designee will complete hygiene observation weekly for four weeks, then monthly for three months to ensure ongoing compliance. Plant Ops Director or designee will monitor cleanliness during daily rounds ongoing.

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented [redacted] - 05/04/2026)

101o - Walls, Floors, Ceilings

6. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On [redacted] in room [redacted] there is a large gash in the wall near floor measuring approximately 1 foot long by 2 inches wide, the bottom corners of the walls leading to the bathroom were missing paint and spackle on both sides and the carpeted floor in the bedroom area was heavily stained.

Plan of Correction ***Accept [redacted] - 04/14/2026)***

A work order was placed immediately for repairs to room [redacted] Mud cleared off resident's scooter wheels, then carpet cleaned by housekeeping. Repairs made to walls and bumpers put into place by maintenance to prevent damage from scooter. This was completed by 3/23/26.

Executive Director and Plant Ops Director completed environmental rounds including all resident rooms by 3/31/26 to ensure all walls, floors, and ceilings are clean and in good repair.

Plant Ops Director or designee will complete weekly environmental rounds for three months to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented [redacted] - 05/04/2026)

102k - No Common Towel

7. Requirements

2600.
102.k. Use of a common towel is prohibited.

102k - No Common Towel *(continued)*

Description of Violation

There was a used towel in the shared jack and jill bathroom of memory care room [redacted]. The towel was unlabeled. There were no paper towels, mechanical hand dryer or other sanitary means of hand drying in this bathroom.

Plan of Correction ***Accept [redacted] - 04/15/2026)***

The Memory Care Director removed the towel immediately and had it laundered, labeled and returned to the resident's room. Paper towels were provided to the Jack and Jill bathroom. Resident Hand towels will be utilized for the sinks in their bedrooms, paper towel dispensers have been ordered and will be mounted by Director of Plant Ops or designee by 4/30/26 for all shared bathrooms.

The Memory Care Director audited all shared bathrooms to ensure sanitary hand-drying supplies were available on 3/17/26.

Housekeeping will ensure that paper towels are included on their supply check list. The Memory Care Director or designee will ensure during weekly audits for three months that the shared bathrooms have proper separate and labeled supplies.

Licensee's Proposed Overall Completion Date: *04/14/2026*

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

132h - Designated Meeting Place

8. 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 8:22 PM, all residents in the home did not evacuate to a designated meeting place away from the building or to a designated meeting area within the fire-safe area. According to staff and residents interviewed, residents who were not in the area of the simulated fire remained in the doorways in their rooms to be counted.

Plan of Correction ***Accept ([redacted] - 04/14/2026)***

Executive Director immediately re-educated the staff during a Town Hall meeting of the process for evacuation on 3/26/26.

Fire Drill conducted on 4/3/26 to re-educate and demonstrate proper evacuation and procedures. Annual Fire Safety Training scheduled for 4/30/26.

Evacuation plan reviewed with Crocker, the consultant that conducts all fire drills on 4/3/26. Explained the expectations for the evacuation within the fire safe area. [redacted] adjusted [redacted] procedures so that going forward each drill [redacted] will monitor and note whether the team in within compliance and provide education when needed. Executive Director will review fire drill documentation monthly to ensure compliance with evacuation requirements.

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

Implemented [redacted] - 05/04/2026)

141a 1-10 Medical Evaluation Information

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. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident [redacted] medical evaluation dated [redacted] did not indicate that the resident's needs could be safely met at a personal care home.

Plan of Correction ***Accept [redacted] - 04/14/2026)***

Resident [redacted]s medical evaluation was immediately reviewed with the attending provider and updated indicating that the resident's needs can safely be met in the personal care setting.

The Executive Director completed an audit of all new admission and medical evaluations completed within the last three months to ensure completion and compliance by 4/3/26.

Going forward, the Director of Health and Wellness will review all new medical evaluations upon receipt and contact the PCP within 24 hours for any incomplete or noncompliant documentation. Audits will occur weekly for three months by Director of Health and Wellness or designee.

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented [redacted] - 05/04/2026)

181d -Storing Medication

10. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident [redacted] self-administers medications and stores medications in [redacted] room. Resident [redacted] resides with [redacted] spouse who is not capable of self-administering medications. On [redacted] at 10:36 AM, there were several unlocked, unattended medications belonging to resident 4 including, [redacted], and [redacted] tablets in a drawer, and [redacted] in the refrigerator.

Plan of Correction ***Accept [redacted] - 04/14/2026)***

All medications self administered by resident 4 were secured in a locked location with Resident [redacted] and the Wellness Coordinator.

181d Storing Medication (continued)

Director of Health and Wellness re educated resident, spouse, and responsible party of safe medication storage requirements on 3/16/26.

Wellness Coordinator did an audit on 3/17/26 to ensure all residents self administering medications were safely storing their medications.

Director of Health and Wellness or designee will complete monthly medication storage checks during monthly resident room audits for three months.

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented [redacted] - 05/04/2026)

182b - Prescription Medication

11. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On [redacted] at 9:20 AM staff person B administered medications to residents to include the following; [redacted], [redacted] and [redacted] to resident [redacted]. Staff person B is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction ***Accept[redacted] - 04/15/2026)***

Staff person B was immediately removed from medication administration duties pending competency validation and completion of required medication administration training.

Staff person B immediately was re educated in the medication administration training course, observed and demonstrated competency in administration technique prior to returning to medication administration duties. Staff person B completed the full initial medication training on 3/23/26.

A complete audit of all medication administration staff credentials and competencies was completed by the Executive Director on 3/19/26 to ensure compliance with all medication administration staff.

The Director of Health and Wellness or designee will review the Med Tech observation completion monthly for 6 months, then quarterly thereafter.

182b Prescription Medication *(continued)*

Licensee's Proposed Overall Completion Date: *04/14/2026*

Implemented [redacted] - 05/04/2026)

182c - Medication Administration

12. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On [redacted] at 9:20 AM, the home did not place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4) for resident 2, who requires this assistance to take [redacted], put 2 sprays in each nostril daily. Staff person B handed resident 2 the nasal spray and resident 2 self administered the spray in at an incorrect angle in both nostrils and added an additional third spray to [redacted] left nostril.

Plan of Correction ***Accept [redacted] - 04/14/2026)***

Director of Health and Wellness immediately re educated Staff person B on medication administration with nasal spray for those who do not self administer.

All current Med Techs competency validation completed 3/26/26 by Director of Health and Wellness including re educated on administering nasal spray on residents who do not self administer.

Director of Health and Wellness or designee will observe medication pass with a nasal spray once a week if available for four weeks, then monthly for three months.

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented [redacted] 05/04/2026)

183e - Storing Medications

13. 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] drops with an open date of [redacted] belonging to resident [redacted] were the memory care medication cart. According to the manufacturer's instructions the unused portion of this medication should be discarded 28 days after opening.

183e - Storing Medications (continued)

[redacted] *drops with an open date of* [redacted] *belonging to resident* [redacted] *were the memory care medication cart. According to the manufacturer's instructions the unused portion of this medication should be discarded 28 days after opening.*

Repeat Violation [redacted] *et al*

Plan of Correction ***Accept ([redacted] 04/14/2026)***

Eye drops were immediately discarded by the Memory Care Director.

Medication Cart audits were completed on all carts by 3/20/26 by the Memory Care Director and Director of Health and Wellness.

Director of Health and Wellness re-educated Med Techs regarding storage and opening dates on 3/26/26. Review the weekly cart audits that will be completed ongoing by the Med Techs.

Med Techs will complete ongoing weekly cart audits. Director of Health and Wellness or designee will complete a weekly audit for four weeks, then monthly for three months. Director of Health and Wellness will review cart audit findings with Med Tech staff during clinical meetings.

Licensee's Proposed Overall Completion Date: *04/06/2026*

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

185a - Implement Storage Procedures

14. 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] *- take one tab under tongue every 5 minutes as needed. On* [redacted] *this medication was not available in the home. The home had two vials of* [redacted] *on the medication cart, however the resident does not have an order for this strength of the medication.*

On [redacted]*, resident* [redacted] *glucometer was not calibrated to the correct time. Actual time was 10:48 AM, the meter read 9:48 AM.*

On [redacted] *at 5:25 AM resident* [redacted]*'s meter had a reading of* [redacted] *however,* [redacted] *was documented on the* [redacted] *medication administration record (MAR).*

Repeat Violation [redacted] *et al*

Plan of Correction ***Accept* [redacted] *- 04/14/2026)***

The Director of Health and Wellness reviewed Resident [redacted] *chart, order read 0.4mg. Director of Health and Wellness in contact with PCP to ensure they wanted to continue with 0.4. The order in the EMAR was then corrected by Director of Health and Wellness on 3/18/26.*

185a - Implement Storage Procedures (continued)

Resident[redacted]s glucometer time was corrected immediately on 3/18/26 and blood glucose documentation was reconciled with the MAR.

A full audit of all emergency medications, glucometer calibration times, and MAR transcription accuracy was completed by the Director of Health and Wellness by 3/20/26.

Going forward, Med Techs will complete daily medication cart readiness checks, including emergency medication availability and device time verification. The Director of Health and Wellness or designee will complete weekly audits for 4 weeks, then monthly for 3 months.

Licensee's Proposed Overall Completion Date: *04/07/2026*

Implemented [redacted] - 05/04/2026)

187a - Medication Record

15. 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 one by mouth 4 times a day, [redacted] dissolve 1 packet in 8 ounces of fluid then drink once a day, and [redacted] 10 cell capsule take one capsule by mouth once a day. However, resident's [redacted] medication administration record does not indicate diagnosis or purpose for the medication, including pro re nata (PRN).

Plan of Correction ***Accept [redacted] - 04/14/2026)***

Director of Health and Wellness contacted the pharmacy to immediately correct that the purpose of the medication was listed, pharmacy corrected.

Director of Health and Wellness audited all of the medications to ensure each had a listed diagnosis or purpose. Any missing, pharmacy was contacted for corrections.

Regional Director of Health and Wellness placed a lock in the EMAR system that all orders cannot be saved without a reason being selected. Director of Health and Wellness will complete a monthly audit for three months to ensure

187a - Medication Record (continued)

this new process is working.

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented [redacted] - 05/04/2026)

225c - Additional Assessment

16. 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] assessment, dated [redacted] does not include an accurate assessment of the resident's needs for transfers or turning and positioning both are listed as no need or NA for the resident however on [redacted] there is a bedside mobility device attached to the residents' bed. The assessment for Resident [redacted] does not address the residents need for a bedside mobility device.

Plan of Correction ***Accept [redacted] - 04/14/2026)***

Resident 9's assessment was updated to reflect the use of the bedside mobility device.

Executive Director audited all the assessments of resident's using bedside mobility devices to ensure accuracy within all assessments.

Director of Health and Wellness or designee will complete monthly audits for three months of all residents using durable medical equipment to ensure the assessment accurately reflects transfer, ambulation, and positioning needs.

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

Implemented [redacted] 05/04/2026)

233c - Key-Locking Devices

17. Requirements

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

Description of Violation

On [redacted] the directions for operating the home's locking mechanism were not conspicuously posted near the door to the Secure Dementia Care Unit (SDCU) on level 1. An incorrect code was posted.

Plan of Correction ***Accept [redacted] - 04/14/2026)***

Executive Director immediately replaced the posted instructions with the correct code signage on 3/16/26.

Executive Director checked all codes to ensure they were correct on 3/17/26

Plant Ops Director or designee will ensure posting with correct code is secured during ongoing monthly environmental rounds

233c - Key-Locking Devices *(continued)*

Licensee's Proposed Overall Completion Date: *04/06/2026*

Implemented [redacted] - 05/04/2026)