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

June 10, 2026

[redacted]
LEGACY AT BRISTOL INC
[redacted]

RE: LEGACY GARDENS OF BRISTOL
2022 BATH ROAD
BRISTOL, PA, 19007
LICENSE/COC#: 13108

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/19/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LEGACY GARDENS OF BRISTOL* **License #**: *13108* **License Expiration**: *02/13/2027*

Address: *2022 BATH ROAD, BRISTOL, PA 19007*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *LEGACY AT BRISTOL INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *23* **Waking Staff**: *17*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *03/19/2026*

Inspection Dates and Department Representative

03/19/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served**: *20*

Secured Dementia Care Unit

In Home: *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**: *20*

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

Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

03/19/2026 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/16/2026*

04/16/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/14/2026*

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

Inspections / Reviews *(continued)*

04/23/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/14/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/21/2026*

06/10/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/14/2026*

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

17 - Record Confidentiality

1. 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 09:00 AM, the home's medication closet located right next to the office was unlocked, unattended, and accessible. Inside the closet were residents' medications and medical information.

Plan of Correction ***Accept [redacted] - 04/23/2026)***

To correct this violation, we ordered and are in the process of installing an auto-lock that uses codes. In addition, we have ordered a recorded device that is motion sensitive and will speak, as a reminder, to the medtech who is present to close and lock the door "when you leave" the med station. This is for our immediate and ongoing correction to this violation.

All med techs were trained when the new, auto-lock was installed on April 10, 2026. The training covered the use of the locks (how to operate them) and the importance of using the new lock. Each med tech has been given a separate code to use the lock and start of use was April 10, 2026. The voice recorder as a reminder to lock the med doors when a med tech is away from the med station was also discussed during the training. The voice recorder will be discontinued when compliance with securing medications is consistent. The maintenance tech and floor supervisor provided the training.
Compliance is monitored daily, for a period of two months from the training date (April 10, 2026) by the Director of Resident Care and the Floor Supervisor to evaluate the effectiveness of this new procedure.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented ([redacted] - 06/10/2026)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

On [redacted] around 09:20 AM, a blue bath robe which was stained with feces was observed hanging in resident [redacted] bathroom.

T approximately 9:30am, the toilet in the bathroom in resident room [redacted] had feces smeared on the back of the seat.

Plan of Correction ***Accept [redacted] 04/23/2026)***

Legacy Gardens is now trying out reminder cards given to each Direct Care staff at the start of each shift. The purpose behind this idea is to instill good habits. Once the habit is learned we will discontinue the use of the cards. The effectiveness of this process will be monitored daily for a period of 2 months by the floor supervisor.
Resident [redacted], on review of [redacted] assessment and care plan, is receiving appropriate care for [redacted] needs. A training on Change of condition and appropriate response is scheduled for 4/23/2026 for all Direct Care Staff. Topics to be addressed include types of things we should be observing for and reporting, using your knowledge and skills to

85a Sanitary Conditions (continued)

respond to the change. The Floor Supervisor does a daily walk through, checking resident rooms for sanitation, supplies available to the resident and to the staff, and [redacted] documents [redacted] findings.
The supervisor shares with the DCS anything [redacted] sees that needs improvement. This daily walkthrough began Jan. 6, 2026 and is ongoing.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 06/10/2026)

88a - Surfaces

3. Requirements

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

Description of Violation

On [redacted] around 09:30 AM, the exit door by room [redacted] had a large brown draft guard stuck under the door creating a tripping hazard.

The floor in front of the kitchen was wet and water was seeping up through the floor when walked on. The water is coming from a dishwasher in the kitchen area that has had a leak since[redacted]

Plan of Correction ***Accept [redacted] - 04/23/2026)***

The draft guard was immediately removed at the time of inspection. and the door draft has been repaired. Maintenance will check the fire doors during [redacted] daily rounds.
At the time of inspection Hobart was waiting for the needed part to come in so they could not schedule a repair until they had the part was in their possession. The dishwasher has now been repaired. Repairing it timely was not due to negligence, but instead it was because after their first repair visit they noticed a leak in a pipe under the first repair and so another part was ordered and repaired when the part came in. We are now in the process of replacing the wainscoting that was damaged due to the leak.
Education was provided by the Director on 3/20/2026 with the maintenance person regarding the need to communicate "preventative maintenance" when doing [redacted] daily rounds in order to ensure a safer environment for our residents. The Director will review maintenance walkthrough documentation weekly for one month and then monthly ongoing to ensure all areas of the home are in good repair, free of hazards and that any areas not compliant are addressed timely to prevent re occurrence of this violation. The weekly audits by the E.D. will begin 4/17/2026 and then monthly audits beginning May 15,2026.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 06/10/2026)

102i - Soap Dispenser

4. Requirements

2600.

102i - Soap Dispenser *(continued)*

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On [redacted] at 09:30 AM, there were two unlabeled used bars of soap in the shared shower room across from room #5.

Plan of Correction ***Accept [redacted] - 04/23/2026)***

Soap bars were immediately removed on the day of inspection. The shared bathrooms in the common areas are now checked by the floor supervisor during [redacted] daily rounds. We are not allowing use of bar soaps in any shared bathroom.
Labels are being used for the shared resident bathrooms designating each resident's supplies including soap, towels, shelf usage in the closet etc. We educate families who request a shared room (companion suite) to label soap dispensers and not to bring in bar soaps as they are not permitted in shared rooms. The labels are applied by the floor supervisor when a new resident moves in.
Compliance is audited by the floor supervisor during [redacted] daily walkthroughs.
The public bathrooms have signs indicating bar soaps cannot be left in these bathrooms. The soap dispensers in the public bathrooms are labeled East or West Hall. This is being audited during the floor supervisor's daily walkthroughs to ensure compliance ongoing.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 06/10/2026)

125a - Combustible Storage

5. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On [redacted] at 09:18 AM, three large cardboard boxes were observed touching the heating system in right side mechanical room. In the other mechanical room which was very hot, a very hot bottle of hand sanitizer was on a tilted makeshift shelf next to the heater. The bottle indicated that it's contents are flammable. Multiple papers were pinned to the heater. A metal cabinet filled with flammable liquids, WD 40, paints, and other sprays, was warm to the touch. The cabinet had keys in the lock and it was easy to open. There was a heavy odor of chemical fumes when the cabinet door was opened.

Plan of Correction ***Accept [redacted]S - 04/23/2026)***

All combustible and flammable materials identified during the survey were removed from contact with heat sources in the mechanical rooms, including cardboard boxes, papers, and a bottle of hand sanitizer. WD-40, paints, and sprays, were relocated to an approved flame proof storage cabinet which is now kept locked with controlled access. the makeshift shelving and any items pinned or attached to heating equipment were removed. A building inspection of all mechanical, storage, and utility rooms was conducted on 4/12/2026 to ensure no additional hazardous storage exists. Signs have been posted on all maintenance doors that no storage is permitted near heat sources. The maintenance director will conduct weekly inspections of these areas, and any concerns will be corrected immediately and reviewed monthly by administration to ensure ongoing compliance. The Maintenance Director has been

125a - Combustible Storage (continued)

conducting weekly inspections of these areas since April 10,2026.
A training session was conducted April 12th, 2026, by the Maintenance Director. The staff trained included maintenance staff and Direct Care staff. Training topics included proper storage of combustible and flammable materials, fire safety requirements related to heat-producing equipment, identification of hazardous storage conditions, and procedures for maintaining compliance with facility safety policies.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] 06/10/2026)

144c1 - Smoking Area Guidelines

6. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On [redacted] around 09:05 AM, the home's designated smoking area was observed with a large black trash bag leaning next to the cigarette butt tower.

Plan of Correction ***Accept[redacted] - 04/23/2026)***

On date of inspection, 3/19/26, the trash bag was immediately removed. Maintenance will check this area in the mornings upon arrival to ensure the area is free of combustible materials to ensure ongoing compliance.
Training will be provided for all staff on 4/14/2026 by the maintenance director. Topics to be covered: Legacy Gardens Smoking Policy, proper safeguards inside and outside of the home to prevent fire hazards, and no combustible materials are allowed in the designated smoking area.

Licensee's Proposed Overall Completion Date: *04/24/2026*

Implemented [redacted] - 06/10/2026)

181f - Record of Medication

7. Requirements

2600.
181.f. The resident's record shall [redacted]clude a current list of prescription, CAM and OTC medications for each resident who is self-administering [redacted] medication.

Description of Violation

On [redacted], resident [redacted]'s record did not include a current list of medications. The list in the resident's record did not include over-the-counter medications such as [redacted], [redacted], and [redacted] and prescription medications such as [redacted], [redacted], and [redacted].

181f - Record of Medication *(continued)*

Plan of Correction ***Accept [redacted] - 04/23/2026)***

The omission of CAM and OTC medications from Resident [redacted]s record has been rectified. The monthly med checks by the Director of Resident care with this resident will monitor this ongoing and will be documented on [redacted] MAR.
On April 1st, 2026, the DRC inspected the locked box of Resident [redacted] and listed the medications that were present in the box. A list was made and placed in the MARS' signed and initialed by the DRC. All OTC and prescribed medications were included. The DRC then sent the list to [redacted] approved what [redacted] is taking and agreed the resident is capable of self-administering [redacted] medications.
Please note there was no [redacted] as was indicated in the violation report, but there was [redacted] which was added to the list. The DRC explained the details of self-administration to Resident [redacted] and the resident said [redacted] understands. and ongoing [redacted] will let us know when any med is changed, discontinued or added.
All staff are offered two trainings per month. The Medication Self-administration training was completed beginning March 1 and ending by the 31st of March. The Floor Supervisor continues to monitor these trainings each month. The topics include what to look for in resident rooms, proper storage, what the staff can and cannot do for a resident self-administering their meds, when and how to report changes or concerns. The med list kept in the MARS must match what is in the locked box and reconciled the beginning of each month ongoing for the entire year, by the DRC. This audit by the DRC will ensure all documentation is correct and all current meds are present.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] 06/10/2026)

183b - Meds and Syringes Locked

8. 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 09:00 AM, the home's medication closet housing all the residents' medications was unlocked, unattended, and accessible.
Resident [redacted] had a bottle of Thera tears unlocked on the bed side table at approximately 9:27am.
At 9:09am, a lidocaine patch was sitting on an unattended small table in the dining room in front of the office and staff A stated that it was for resident [redacted] and that the staff person set it there because they were going to apply it to the resident.

Plan of Correction ***Accept [redacted] - 04/23/2026)***

Thera Tears were removed from resident [redacted]s room and returned to the Med station.

All med techs on April 10, 2026 were re-educated on the importance of securing all medications they are administering, until the meds are safely administered to the resident they are intended for and safely returning any meds such as eye drops, nystatin cream, nasal sprays etc. to the med station when finished. All MedTechs were informed of our home's policy and regulation requirements for medications to be locked and inaccessible and the proper procedures they should take when delivering medications to residents. The topics included securing of the medications until the meds are safely delivered to the resident they are intended for, and safely returning any other

183b Meds and Syringes Locked (continued)

meds to the med station when finished.
The communication to the resident families took place on February 1st, 2026, explaining that all medicine whether prescribed or CTC, including syringes shall be kept in an area or container that is locked. If any medications are brought in, they must be given to the DRC. Any resident giving their own meds must have a locked box and a physician's order approving med self administration.
Resident rooms are checked daily for any medications that families might bring in. This check is done by the floor supervisor.

Random checks during med pass daily will be done to prevent this violation from re occurring. Observation of a closed and double locked med door, and no observed meds left out on the desk or surrounding areas. All medtechs, nurses and director are responsible for monitoring the med station ongoing.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 06/10/2026)

183d - Prescription Current

9. Requirements

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

Description of Violation

On [redacted], a bottle of [redacted] belonging to resident [redacted] was present in the medication closet. The resident does not have a current order for this medication. Additionally, [redacted] prescribed for resident [redacted] on [redacted] to be administered as 1 drop to left eye for 10 days, was still in the home's medication closet.

Plan of Correction ***Accept [redacted] - 04/23/2026)***

Resident [redacted] Tylenol was immediately removed from the medication closet. An order for the Tylenol was obtained and is now located in [redacted] blister pack and documented for compliance. On 4/10/2026 all med techs were educated regarding the observing and reporting of any meds seen in a resident's room. Any medication in a resident's room should be brought to the office and given to the Director of Resident Care.
Ongoing this will be monitored by the floor supervisor and Practicum Observer during a weekly check of the resident MARs.
Every Friday the Practicum Observer and the DRC will audit the med station for any time limited medicine and remove and discard any medication if it's past the end date. The Floor Supervisor and the DRC will be auditing bi weekly for a period of six months, until the task is learned and a habit is formed. The DRC will continue to reconcile meds on the first of each month. This audit was initiated March 23rd, 2026, and will be continued through September to ensure compliance.

Ongoing, the medtech on duty will take responsibility for checking expired meds, or time limited meds. Although it is all med techs and nurse's responsibility to monitor these things, ultimately the med tech on duty will be responsible tom ensure compliance.

183d Prescription Current *(continued)*

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] 06/10/2026)

183e - Storing Medications

10. 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] a blister package of [redacted] prescribed for resident [redacted], which expired on [redacted], was still in the home.

[redacted] prescribed for resident [redacted] was opened but not dated. According to the manufacturer's instructions, the unused portions of the medication should be discarded 6 weeks after opening.

Plan of Correction ***Accept [redacted] - 04/23/2026)***

Resident [redacted] Tylenol in the med station was removed and discarded immediately.
On Mondays and Fridays, the DRC and Practicum Observer will audit the MARS and expired meds. Any expired meds noted will be discarded. Then a new order will be obtained if the MD agrees and documented on the MARS. These audits will begin 4/27/2026.
On April 10,2026 all med techs were retrained on looking at dates to check for expired medications. We went over where to check if we are unsure when a medication expires as the pharmacy training on expiration dates of many common medications is kept at the med station. Both the Practicum Observer and the DRC will perform bi weekly audits of expiration dates and the MARS for a period of six months. October 1st is the anticipated duration.
The training on April 10th, 2026, included medications that must be dated when the package is opened such as eye drops, ointments, insulin etc.
This is being checked weekly by the DRC and Practicum Observer to ensure compliance ongoing.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] 06/10/2026)

187b - Date/Time of Medication Admin.

12. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted], the resident's March 2026 MAR does not include the initials of the staff person who administered it on [redacted] at 11:00 PM and on [redacted] at 01:00 AM and at 09:30 AM, however the home's Narcotic Inventory log indicates the medication was removed from medication storage area on these dates and times.

Resident [redacted] is prescribed [redacted] as needed. The resident's March 2026 MAR does not include the initials

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

of the staff who administered it on [redacted] at 03:00 AM and [redacted] at 02:00 AM. The homes Narcotic Inventory log indicates that these medications were removed from the medication storage area at these dates and times.

Additionally, resident [redacted] went out for an overnight stay with family on [redacted] and came back on [redacted]. The resident's night medications on [redacted] and morning medications on [redacted] were administered by family; however, the home's staff documented these medications as administered by the staff of the home on the resident's March 2026 MAR.

Repeat Violation: [redacted]

Plan of Correction ***Accept [redacted] 04/23/2026)***

Med techs on all shifts were re-educated on April 10, 2026 regarding the need to document an administered narcotic not only on the Narcotic Count Sheet but also on the MAR for the resident requesting the medication.
Our procedure now for documenting an absent resident's MAR is to document with an "A" for absent the dates the resident is not at Legacy Gardens. If it is a stay with family, upon the residents return, the meds will be reviewed, counted and documented on the back of the MAR with a note that states the number of medications given during the stay by the resident's family. Ongoing in addition to the pharmacy's review, our Practicum Observer and DRC will do a bi-weekly audit of the MARS until there is consistent compliance with this medication regulation.
Bi-weekly reviews started on 3/13/2026 and will be continued for a period of six months until October 1, 2026, when the responsibility of weekly checks by medtechs will begin and be ongoing.

Licensee's Proposed Overall Completion Date: *05/14/2026*

Implemented [redacted] - 06/10/2026)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident [redacted] is prescribed glucose level check once daily in the morning. However, the resident's glucose level check is done only on Mondays and Fridays at resident's daughter's request. The resident's glucose level was not checked on any other days than Mondays and Fridays and also specifically on Friday [redacted]

Repeat violation date: [redacted]

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

This resident's order now reads "Glucometer checks once daily on Mondays and Friday's" All med staff were reminded of this in the training held April 10, 2026 and of the need to immediately document the results on the resident's MAR. This will be monitored daily by the med tech staff and weekly by the Practicum Observer.

Licensee's Proposed Overall Completion Date: *12/31/2026*

Implemented [redacted] - 06/10/2026)

224a - Preadmission Screen Form

14. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident [redacted] preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Directed ([redacted] - 04/23/2026)***

The root cause of this violation is due to the absence of our nurse during this time period. The nurse returned to work on the day this resident we admitted to Legacy Gardens. The prescreen is normally done before the date of admission. We believe this to be an isolated incident . It has since been corrected by the DRC.
Ongoing when we are notified on the date of a new admission the pre-screen, which is now in our move-in paperwork, will be pulled and scheduled to be completed as soon as possible before the date of admission. This will be done by the DRC and followed up with audit by the Executive Director to ensure compliance. The DRC and E.D. will begin an audit of all resident files on May 1,2026 with an anticipated completion date of July 31,2026.

Directed plan of correction: An initial audit of all resident files shall be completed by the administrator or designee within 15 business days of the receipt of this plan of correction. An ongoing audit of all new admissions paperwork shall be completed by the administrator or designee weekly beginning with the receipt of this plan of correction. Documentation of completed audits including details of what was audited, who completed the audit, what was observed, and any corrections needed and made, will be kept and made available to the Department upon request.

Directed Completion Date: *05/14/2026*

Implemented [redacted] - 06/10/2026)

225a - Assessment 15 Days

15. Requirements

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

Description of Violation

An assessment was not completed for resident [redacted] who was admitted to the home on [redacted]

Plan of Correction ***Directed [redacted] - 04/23/2026)***

The RASP form for every new admission is now in the residents move-in folder. When we are notified of the date of admission, the prescreen will be scheduled to be completed prior to the admission. Next the assessment part of the RASP will be scheduled for completion by the admission staff person within 15 days of resident's admission to Legacy Gardens.
All new admissions up until todays date (4/21/2026), have been reviewed by the DRC and a second time by the Executive Director. all needed items are in place, and our plan is to put dates on a whiteboard in the office (or a calendar) or both with the 15-day marked for the assessment to be completed. The responsible party for this task is the DRC and will be audited by the Director upon completion.

225a Assessment 15 Days (continued)

All resident files are planned to be reviewed to ensure a timely assessment has been completed. These audits will be done by the DRC and a second time by the ED to ensure compliance. The reviews will begin May 1, 2026 with an anticipated completion date of July 31, 2026.

Directed plan of correction: An initial audit of all resident files shall be completed by the administrator or designee within 15 business days of the receipt of this plan of correction. An ongoing audit of all new admissions paperwork shall be completed by the administrator or designee weekly beginning with the receipt of this plan of correction. Documentation of completed audits including details of what was audited, who completed the audit, what was observed, and any corrections needed and made, will be kept and made available to the Department upon request.

Directed Completion Date: *05/14/2026*

Implemented ([redacted] 06/10/2026)

227a - Support Plan 30 Days

16. Requirements

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

Description of Violation

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

Plan of Correction ***Directed [redacted] - 04/23/2026)***

The RASP form for every new admission is now in the resident's move in folder. When a new admission is scheduled, the support plan will be scheduled for completion within 30 days of the resident's admission date. This task will be the responsibility of the DRC and the Executive Director will audit the completion of the support plan to ensure it is completed in its entirety by 30 days from admission.
On May 1, 2026, the DRC will review all resident files to ensure a timely support plan has been completed and a second review will be done by the ED to ensure all required documents are completed and timeframes are met. We anticipate an end date of July 31, 2026, for all resident reviews and follow up audits.

Directed plan of correction: An initial audit of all resident files shall be completed by the administrator or designee within 15 business days of the receipt of this plan of correction. An ongoing audit of all new admissions paperwork shall be completed by the administrator or designee weekly beginning with the receipt of this plan of correction. Documentation of completed audits including details of what was audited, who completed the audit, what was observed, and any corrections needed and made, will be kept and made available to the Department upon request.

Directed Completion Date: *05/14/2026*

Implemented [redacted] - 06/10/2026)