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

July 14, 2026

[redacted], OWNER
ROSALIE J DAPICE
PO BOX 6363, 528-30 PRESSLEY ST
PITTSBURGH, PA, 15212

RE: HENDERSON HOUSE
P.O.B. 6363,528-30 PRESSLEY ST
PITTSBURGH, PA, 15212
LICENSE/COC#: 43095

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/23/2026, 03/30/2026 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: *HENDERSON HOUSE* **License #**: *43095* **License Expiration**: *03/10/2027*

Address: *P.O.B. 6363,528 30 PRESSLEY ST, PITTSBURGH, PA 15212*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *ROSALIE J DAPICE*

Address: *PO BOX 6363, 528-30 PRESSLEY ST, PITTSBURGH, PA, 15212*

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *12/29/1992* **Issued By**: *City of Pittsburgh*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *03/30/2026*

Inspection Dates and Department Representative

03/23/2026 - On-Site: [redacted]

03/30/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* **Residents Served**: *18*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *13*

Diagnosed with Mental Illness: *18* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

03/23/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/07/2026*

05/08/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/04/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/14/2026*

Inspections / Reviews *(continued)*

05/18/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/04/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/03/2026*

07/14/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/04/2026*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #5 is currently prescribed Ozempic 4mg/3ml-Inject 1mg into the skin every 7 days for diabetes. Resident #5 was not administered this medication on 3/21/26, because the medication was not available in the home for administration; however, this medication error was not reported to the Department.

Plan of Correction ***Directed (- 05/18/2026)***

Immediate Action:
on 3/24/26 the owner administrator phoned the provider for direction on the restarting of Ozempic for resident #5. the Ozempic was restarted on ____04/03/26____.
Phys order is attached to this report.
A late report of a medication error was prepared by the owner/adm and will be attached to this report
Continued compliance:
The Owner Administrator or designee will re-educate all medication techs on the requirement of 2600. 16c. The education will take place on 5/22/2026. Education will be attached to this report.
The Owner Administrator or designee will audit the MAR monthly to ensure 260.16 is in compliance. Monthly MAR Audits began 4/2026 and is attached to this report.
QM: Medication errors and compliance with 2600.16 c will be reviewed at the next QM meeting scheduled for 6/3/2026 (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

DIRECTED: Beginning on 5/20/26: The administrator/designee shall review all internal incidents daily to ensure all incidents specified in 2600.16a are reported to the Department within 24 hours in accordance with 2600.16c.
[redacted] 5/18/26

DIRECTED: By 5/20/26: The administrator shall ensure the medication error involving resident #5's Ozempic on 3/21/26 is reported to the Department. A copy of the incident report shall be placed in resident #5's record. [redacted]
5/18/26

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

25c4 - Payment Responsibility

2. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
4. The party responsible for payment.

Description of Violation

Resident #2's resident-home contract, dated [redacted] does not specify the party responsible for payment.

25c4 Payment Responsibility *(continued)*

Plan of Correction ***Directed (- 05/18/2026)***

Immediate: On 3/25/26 the Administrator/owner inspected the resident home contract of resident #2 dated [redacted] On 4/1/26 the party responsible ([redacted] Payee Service) for the payment was added. Resident #2 and the Administrator /owner initialed the late entry. A copy of this page of the contract will be attached to this report.
Continued Compliance: May 2026 the Administrator or designee will audit 100% of the resident home contracts for compliance with 2600.25c4. Audit will be complete by 5/22/26 and included in this report
Administrator/owner or designee will complete random audit of 4 resident home contracts monthly for three months June, July August of 2026. Audits will include any new residents admitted to the home during that time period.
For educational/review purposes the Administrator/owner will review 2600.25c4. by 5/22/26
QM: The violation and audits will be reviewed at the next QM meeting of 06/03/2026 (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

Proposed Overall Completion Date: 05/29/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

51 - Criminal Background Check

3. Requirements

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

Description of Violation

At the time of inspection, no Pennsylvania criminal background check was present for direct care staff person C, who was hired on [redacted]

Plan of Correction ***Directed (- 05/18/2026)***

Immediate: On 5/25/26 the Administrator/owner applied for a PA criminal background check for staff person C who was hired of [redacted] It is currently under review. The application will be attached to this report. The final report will be sent to the Department when it is received.
Continued Compliance: The home does use a new hire check list, however the crim check was misplaced at some time during the employees [redacted] plus years of service. The administrator/owner or designee will audit all employee files for compliance with 2600.51. Audit and administrators review of the regulation will be completed by 5/22/26. The home is small and employs only 4 6 staff at any one time. The administrator or designee will review the check list within 30 days of any new hire. There are no new hires since the last inspection. The criminal background check of staff member C appears to have been lost in subsequent years after the hire date [redacted]
QM: The violation and compliance will be reviewed at the next QM meeting scheduled for 06/03/26. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

51 - Criminal Background Check (continued)

Proposed Overall Completion Date: 05/30/2026
Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

65g - Annual Training Content

4. 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.

Description of Violation

The following direct care staff persons have not received fire safety training conducted by a fire safety expert or by a staff person trained by a fire safety expert during the 2025 training year:

- *Direct care staff person A, hired*
- *Direct care staff person B, hired*
- *Direct care staff person C, hired*
- *Direct care staff person D, hired*
- *Direct care staff person E, hired*

Plan of Correction ***Directed (- 05/18/2026)***

Immediate Action: On 3/27/26 the Administrator//owner scheduled Fire Training with Summitt fire and Safety. Training for staff person A, B, C, D, E was completed on 4/10/26. Record of the training will be attached to this report and kept in the facility files. All employees, ancillary staff and volunteers of the home were trained by the Summitt Fire and Safety on 4/10/26. Documentation is attached.
Education: The Administrator/Owner and a designee have reviewed the training requirement. The review/educucation was completed on 4/10/26. Documentation of the review will be attached to this report
Continued compliance: The Administrator/owner has enlisted to complete the Fires Safety requirements for the facility. has been added to the facility calendar to be enlisted for all training,, observation of a drill and documentation of safe evacuation times for the year of 2026 and moving into 2027. The administrator or designated person will audit the training files quarterly to ensure the training complies with 2600.65. First audit will take place by June 1, 2026 and will be reviewed at the QM meeting of 6/3/26
QM: Fire safety policy, progress and compliance will be reviewed at the next QM meeting scheduled for 06/03/2026. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On 3/23/26 at approximately 10:00am, there were dozens of small black rice-like pellets, which appeared to be mice feces, present throughout the bottom of the 2nd floor dining room sink cabinet.

Plan of Correction ***Directed (- 05/18/2026)***

Immediate Action: On 3/25/26 the administrator/owner removed the cabinet liner and disinfected the inside of the cabinet. A glue trap was placed in the empty cabinet, The cabinet will remain empty for 90 days. A sign was posted on the front on the cabinet (by The administrator) DO NOT PLACE ANYTHING IN THIS CABINET.Cabinet will be check daily by the administrator or designee. Any evidence of rodent activity will be reported to the administrator. on 5/1/26 check sheet was attached to the cabinet for daily documentation. it will be attached to this report.
An check of all cabinets in the kitchen was competed by the Administrator/owner on 4/27/26. No evidence of rodent activity was noted.. Documentation will be included in this report.
Continued Compliance: Kitchen and dry goods storage will be checked weekly beginning 5/1/26 for two months and thereafter monthly. If any further evidence of rodent activity is found and exterminator will be called. There has been no further evidence of rodents per the daily checks of the cabinet started 3/27/26. or the weekly checks of dry goods storage that were started 5/1/26. AS of 5/13/26 no rodent activity has been reported, however the administrator has scheduled an exterminator (to inspect and treat the bld on 5/19/26.. Documentation will be attached to the final report
Education: All staff will be further educated on the importance of the weekly checks and reporting of suspected rodent activity. Education will take place by 5/22/26. Staff were verbally educated on 3/26/26 by the administrator. Residents will be educated on the importance of any snacks kept in their rooms be in a sealed container. Resident education will take place by 5/22/26
As of the date of this report 5/14/26 the home has not seen any further evidence of rodent activity. There have been no reports by staff or residents of suspected sightings. Daily checks of the cabinet droppings were found in will continue for 90 days. Weekly checks of dry good storage will continue monthly for 90 days.
The exterminators visit of 5/18/26 findings and recommendations will be attached to the final report. Findings of the continued monitoring will be reviewed at the next QM meeting of 6/3/26. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

89a - Water Pressure

6. Requirements

2600.

89a Water Pressure *(continued)*

89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 3/23/26 at approximately 10:00am, the hot water temperature at the sink in the 2nd floor bathroom near bedroom #208 was 66.7 degrees Fahrenheit.

On 3/23/26 at approximately 10:15am, the hot water temperature at the sink in the 2nd floor bathroom near bedroom #204 was 66.5 degrees Fahrenheit.

Plan of Correction ***Directed (- 05/18/2026)***

Immediate: on 3/27 26 the Administrator owner call a plumber to inspect hot water heaters. On 4/15/26 [redacted] plumbing installed regulators on the water tanks supplying the first, second and third floor areas. Temperatures were set at 115 degrees. A copy of the invoice is attached.
Continued Compliance: The Administrator or designee will monitor temperature in the first, second and third floor bathrooms and the dining room sink weekly for compliance with 2600..89 a and 2600.89b. If temperatures are found below 100 degrees or above 120 degrees the plumber will be scheduled. Weekly temperature charts will be placed on the bathroom doors by 5/22/26. Charts will be included in this report. Water temperature checks will remain weekly for two months and then will be taken monthly
Education: Staff will be educated by the administrator on the use of the temperature charts on 5/22/26. Education will be included in this report.
QM: The violation and monitoring eefforts will be reviewed at the next QM meeting scheduled for 06/03/2026. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

89b - Hot Water Temperature

7. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 3/23/26 at 10:05am, the temperature of the hot water at the sink in the 2nd floor dining room was 136.2 degrees Fahrenheit.

On 3/23/26 at 10:41am, the temperature of the hot water at the sink in the 2nd bathroom near bedroom #207 was 135.6 degrees Fahrenheit.

Plan of Correction ***Directed (- 05/18/2026)***

Immediate Action: On 3/27 26 the administrator scheduled [redacted] plumbing to evaluate the hot water to the first floor bathroom, 2nd floor bathrooms, 3rd floor bathroom and the dining room sinks. On 4/15/26 [redacted] installed regulators to the water tanks supplying the above areas. Water temperatures were set not to exceed 115 degrees. Invoice will be attached to this report

89b - Hot Water Temperature (continued)

Continued Compliance: Water temperatures will be monitored weekly for two months and monthly thereafter. Should temperatures fall below 100 degree or above 115 degrees the administrator will call [redacted] plumbing. (DIRECTED: The weekly hot water checks shall begin on 5/20/26. Documentation of the hot water checks shall be kept. [redacted] 5/18/26).
QM: The violation and monitoring efforts will be reviewed at the next QM meeting scheduled for 06/03/2026. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented ([redacted] - 07/13/2026)

91 - Telephone Numbers

8. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 3/23/26 at approximately 3:30pm, none of the emergency telephone numbers specified in 2600.91 were posted on or near the landline telephone in resident #4's bedroom.

Plan of Correction ***Directed ([redacted] - 05/18/2026)***

Immediate Action: Resident # 4 is the only resident with a private landline phone in [redacted] room. On 3/26/26 the administrator place the emergency phone numbers on the bedside stand of resident #4 phone.
On 3/26/26 all other landline phones in the home were checked for the placement of Emergency Phone numbers. All were in compliance except for resident # 4 bedroom phone.
Continued Compliance: Required postings will be check monthly by the Administrator or designee. Monthly checks began of 3/26/26. Checks will be documented ad attached to this report. Education of all staff will take place by 5/22/26 and will be attached to this report
QM: the violation and the continued compliance will be reviewed at the next QM meeting scheduled for 06/03/2026. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented ([redacted] - 07/13/2026)

96a - First Aid Kit

9. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

96a First Aid Kit *(continued)*

Description of Violation

On 3/23/26, no thermometer was present in the first aid kit located in the 2nd floor laundry area.

Plan of Correction ***Directed (- 05/18/2026)***

Immediate: On 3/26/2026 Administrator/owner placed a thermometer in the first aid kit located in the 2nd fl laundry area.
Continued Compliance: For 60 days first aid kits (3) will be checked weekly by the administrator or designee. A list of all requirement of 2600.96 will be placed inside all three kits by 5/22/26. thereafter be checked monthly. All check lists will be included in this report.
Education: Staff education on 96a will be completed by 5/22/26. Education will be included in this report and kept in the facility.
QM: The violation and continued compliance efforts will be reviewed at the next QM meeting scheduled by 06/03/26. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

101j3 - Bed/Linens/Pillows/Blankets

10. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 3/23/26 at 3:25pm, resident #1's pillowcase was covered in blue pen markings. Also, resident #1's pillowcase and fitted sheet had several red and brown stains, which appeared to be dried blood.

Plan of Correction ***Directed (- 05/18/2026)***

Immediate: On 3/23/26 the administrator instructed staff to change all the linens on resident #1"s bed.
Continued compliance: Resident #1 is known to spend most of the day in the bed. The resident often writes using pen while in bed. The resident was assessed by the administrator on 3/24/26 for any small cuts or open areas that could have caused the possible blood stains. There were no open areas noted.
The resident was reminded there are areas in the home with a table for writing and encouraged their use.
The resident is currently has not been determined. When Res #1 returns the staff will check bed linens daily for two weeks. Linens will be changed if necessary. Support plan will then be updated to include the need to check linens daily.
An audit of 4 random beds to include res #1 will be checked weekly by the administrator or designee. Weekly checks of the 4 random beds will begin 5/23/26. if no further stains are noted after 8 weeks, the bed checks will be reduced to monthly at the time of scheduled linen changes
Education: by 5/22/26 all caregivers will be educated by the administrator on 101j3 and monitoring for stains. Any permanently stained linen will be disposed of.. Education and Check list will be included with this report and kept in the facility.
QM: The violation and the linen needs of the facility will be review at the next QM meeting scheduled for

101j3 - Bed/Linens/Pillows/Blankets (continued)

06/03/26. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented ([redacted] - 07/13/2026)

103f - Refrigerator/Freezer Temps

11. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 3/23/26 at 10:08am, the temperature in the 2nd floor dining room freezer measured 15 degrees Fahrenheit, and on 3/30/26 at 1:45pm, the temperature was 3 degrees Fahrenheit.

Plan of Correction ***Directed ([redacted] - 05/18/2026)***

Immediate Action: On 3/26/26 the administrator replaced the thermometer. This refrigerator freezer is available to the residents 24/7 and it is opened and closed frequently. They store snacks and other individual food items. The freezer was checked by the designee at 7am 3/28/26 and registered 0 degrees, The freezer had not been opened for approx 10 hours.
Continued compliance: Freezer temp will be checked and recorded each shift by the administrator or designee. Checks will begin 4/1/26. Temperatures will be recorded on the chart secured to the refrigerator front. On the day of inspection several loaves of bread had been placed in the freezer by a staff member. The fan in the freezer was covered by the bread. By policy, this is not the freezer bread is stored in. On 3/26/26 the staff member was verbally counseled by the administrator. Temperatures will continue to be recorded each shift indefinitely. Documentation will be attached to this report and kept in the facility. If the temperatures at different times of the day fall above 0 degrees the unit will be serviced, replaced or removed by the owner. Checks will be kept in the home.
Education: Staff education on 2600 103f will take place before 5/22/26. Education will be attached and kept in the bld.
QM: This violation and its follow up will be reviewed at the next scheduled QM meeting scheduled for 6/3/2026. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

DIRECTED: Beginning on 5/20/26: The administrator/designee shall check all refrigerators/freezers on a weekly basis to ensure an operable thermometer is present and proper food handling temperatures are maintained in accordance with 2600.103f. [redacted] 5/18/26).

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented ([redacted] - 07/13/2026)

121a - Unobstructed Egress

12. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 3/23/26 at 4:19pm, a pet gate, which measured approximately 2ft in height, was present across the bottom of the main staircase to the 2nd floor, blocking this egress route.

Plan of Correction ***Directed (- 05/18/2026)***

Immediate: On 3/24/26 the Administrator removed the gate. The administrator/owner had set the unsecured gate across the bottom of the main staircase to the second floor. This was to temporarily secure pet. This action will not be repeated.
Continued compliance: The owner administrator reviewed the requirement of 2600.121a. The gate has been put in private residence and will not be used in any area that blocks egress for residents. Attached is the education/review of the administrator. Areas of egress will be checked weekly by the administrator or designee. Checks will begin week of 5/24/26 for 4 weeks and then monthly thereafter.
QM Review of this violation and its continued compliance will take place at the next scheduled QM meeting of 06/03/26. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

130h - Inoperable Smoke Detector

13. Requirements

2600.
130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

Plan of Correction ***Directed (- 05/18/2026)***

Immediate Action: on 5/1/26 Administrator/owner began development of emergency procedure that will be immediately implemented if a smoke detector or fire alarms are inoperable.
The policy and procedure will be complete by 5/22/26 and placed in with the emergency procedures. It will be attached to this report
Education: The administrator or designee will educate the staff on the policy regarding inoperable smoke detectors or fire alarm systems. Education will take place on 5/22/26 and will be attached to this report. The policy will be kept in the homes records.
QM: The violation and its current level of compliance will be reviewed at the homes next meeting scheduled for 06/03/2026 QM meeting notes are available in the facility. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. 5/18/26)

130h - Inoperable Smoke Detector (continued)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

132d - Evacuation

14. Requirements

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

Description of Violation

The evacuation time for the fire drill conducted on 8/13/25 at 1:30am was completed in 2 minutes, 55 seconds; however, the home has no documentation from a fire safety expert within the past year indicating a maximum evacuation time to evacuate the entire building to a public thoroughfare or to a fire-safe area that exceeds 2 minutes, 30 seconds.

REPEAT VIOLATION: 4/22/2025

Plan of Correction ***Accept (- 05/18/2026)***

Immediate: The previous fire safety records were reviewed. The Administrator /Owner decision is to change fire safety providers. The administrator owner contacted fire safety expert [redacted] to inspect the facility, observe a fire drill and document the maximum evacuation time of the entire bld to a public thoroughfare. The results of this inspection will be attached to this report and kept in the facilities records. Date in May 2026 is to be determined by 5/10/26.
Continued Compliance: The homes inspection by fire safety expert [redacted] is determined by [redacted] availability. On 5/13/26 2:00PM [redacted] observed at fire drill and inspected the home. The residents in the home at the time of the drill evacuated in 1min and 32 seconds (15 residents and 3 staff). [redacted] documented the safe evacuation for the home is 3 min and 30 seconds. The documentation will be attached to this report. The administrator or designee shall review all fire drill records monthly to ensure all residents evacuate with the 3 min and 30 seconds the fire safety expert specified on 5/13/26.

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

Implemented (- 07/13/2026)

132e - Fire Drill Sleeping Hours

15. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The most recent fire drill conducted during sleeping hours was held on 3/28/26 at 1:45am; however, the previous fire drill conducted during sleeping hours fire drill was held on 8/13/25 at 1:30am.

132e - Fire Drill Sleeping Hours (continued)

Plan of Correction ***Directed (- 05/18/2026)***

Immediate Action: The administrator/owner reviewed the regulation 132e and completed the night time drill on 3/28/26 at 1:15 AM. Documentation is attached
Continued Compliance: The owner Administrator has created alert on her personal cell phone, private facility calendar to alert the night drill is due. This will not be shared with staff.
Fire drill log will be reviewed both by the administrator and a designee monthly for the next year. The drill log will be initialed by both. This will also act as a reminder of when the next night drill is due. The log will note the month the night drill is due. Example of this will be attached to this report
Education: The Administrator/Owner and a designee will be review the requirements of the night drill and the tracking mechanism of reviewing the drill log each month. Review will take place by 5/22/26 and will be attached to this report and kept in the facility.
QM: The violation and the 2026 fire drill log will be reviewed for compliance
Next QM meeting is scheduled for 6/3/2026 (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

132g - Fire Drills Days/Times

16. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely conducts fire drills during the last weekend of the month, to include the following dates:

- *Saturday, 3/28/26 at 1:45am*
- *Sunday, 2/22/26 at 5:24pm*
- *Saturday, 1/31/26 at 2:06pm*
- *Sunday, 12/28/25 at 4:41pm*
- *Saturday, 11/29/25 at 1:55pm*
- *Saturday, 10/25/25 at 5:29pm*
- *Saturday, 9/27/25 at 1:27pm*

Plan of Correction ***Accept (- 05/08/2026)***

Immediate Action: The owner/administrator conducts all drills. will immediately as of April 2026 vary the dates/days of the week and times of the drills. A drill was conducted on Tuesday 4/14/26 at 11:15 AM Documentation will be attached to this report and kept in the facility via the drill log.
Continued Compliance: The administrator along with a designee will review the fire drill log monthly at the time of the drill to determine approximate when the next drill should take place. They will both initial the log.

132g - Fire Drills Days/Times (continued)

Education: The administrator reviewed the violation and the regulation of 3/27/26. The designee will be educated on the violation and 132g by or on 5/22/26. Education will be attached to this report and kept in the facility records

Licensee's Proposed Overall Completion Date: *05/22/2026*

Implemented (- 07/13/2026)

141b1 - Annual Medical Evaluation

17. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #3's most recent medical evaluation, dated , does not indicate if resident #3's needs can be met safely at the personal care home. This section of resident #3's medical evaluation is blank.

REPEAT VIOLATION: 11/17/2025

Plan of Correction ***Accept (- 05/08/2026)***

Immediate Action: The administrator/owner spoke with the resident #3 and the need to have the medical evaluation reviewed by the residents physician. The resident saw the phys on 4.16.26. The medical evaluation was corrected by the the physician to include that the residents needs could safely be met at the personal care home. The amended medical evaluation is attached to this report.
Continued compliance: The administrator/owner or designee will audit all medical evaluations to ensure they meet the requirements of 141b1. The complete audit will be complete b 5/30/26. Thereafter the administrator/owner or designee will randomly audit 4 medical evaluations monthly to include any new residents. Documentation of the monthly audits will be kept in the facility .
Education: The administrator and designee will review the regulation and educatie the designee on the completion of the monthly audit. Education will take place on or before 5/22/26

Licensee's Proposed Overall Completion Date: *05/30/2026*

Implemented (- 07/13/2026)

162a - Hours Between Meals

18. Requirements

2600.
162.a. There may not be more than 15 hours between the evening meal and the first meal of the next day. There may not be more than 6 hours between breakfast and lunch, and between lunch and supper. This requirement does not apply if a resident's physician has prescribed otherwise.

Description of Violation

According to numerous resident and staff interviews, residents are routinely served their dinner meals at approximately 4:00pm; however, breakfast meals are not served until approximately 8:30am, which exceeds 15 hours between the 2 meals.

162a Hours Between Meals *(continued)*

Plan of Correction ***Directed (- 05/18/2026)***

Immediate: on 3/27/26 administrator/owner began to review the current process, timing of meals and staff availability. There are 4 staff members and the administrator for this small home.
Breakfast current time continues to begin 8:30 am
Dinner current time is 4pm and will be changed to 5:00 pm.
Evening snack will be served between 7:30 and 8:00 pm
This adjustment still does not completely meet the requirements of 15 hour maximum between meals. It is deficient by 30 minutes. Technical assistance is being sought in applying for a waiver. Staffing cannot be adjusted further without losing current staff. Additional staffing has not been successful. Administrator or designee will be in contact with the department for guidance.
A new meal schedule will be effective 6/10/26. Staff schedules will be adjusted by the administrator/owner. The facility will continue recruitment efforts in order to further adjust meal times. Residents will be notified of the meal time change on 5/10/26, A request for a waiver will be sent on 5/18/2026 and will be attached to this report.
QM: The violation, recruitment efforts and staff scheduling will be reviewed at the next QM meeting scheduled for 06/03/2026

DIRECTED: Until such time that the Department approves a waiver regarding meal times, the administrator shall adjust staffing levels to ensure compliance with 2600.162a. [redacted] 5/18/26

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/14/2026)

183b - Meds and Syringes Locked

19. 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 3/23/26 at 10:18am, an unlabeled plastic cup containing 4 different unknown medication tablets was unlocked, unattended and accessible in the 2nd floor medicine cabinet next to bedroom #204.

Plan of Correction ***Directed (- 05/18/2026)***

Immediate action: On 3/23/26 the administrator destroyed the medication that was found in the medicine cabinet. The source or owner of the medication could not be confirmed.
Continued Compliance:
Starting 5/22/26
Medicine cabinets will be checked daily at the time the bathrooms are cleaned. medicine cabinets will be checked by the staff cleaning that day. Any medication found will be reported to the administrator and immediately locked in a secure area until the administrator determines to destroy it. Destruction will be documented. and kept in the facility.
A check list for checking the medicine cabinets will be place in the inside of the bathroom door for staff to document the cabinet has been checked.
Check list will begin 5/23/26. Education of staff will be completed 5/22/26. Check list will sta in place for 30 days if no further findings are noted.

183b Meds and Syringes Locked (continued)

QM: The violation and the resolution of the violation will be reviewed at the next QM meeting scheduled for 06/03/26. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

DIRECTED: Beginning on 5/20/26: The administrator/designee shall inspect the entire home daily to ensure all prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked, which includes medications and syringes kept in the resident's room. [redacted] 5/18/26).

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented ([redacted] - 07/13/2026)

183c - Refrigerated Meds Locked

20. Requirements

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

On 3/23/26 at 10:30am, a black lockbox, which contained 2 boxes of resident #6's Latanoprost 0.005% eye drops, was unlocked, unattended and accessible in the 3rd floor kitchen refrigerator.

Plan of Correction ***Directed ([redacted] - 05/18/2026)***

Immediate Action: On 3/23/26 the administrator/owner or designee locked the box containing the Latanoprost eye drops.
Continued compliance: All medication lock boxes kept in the homes refrigerators will be locked when not in use . A check will be completed by the med tech each shift. for 60 days. Checks begin 5/23/26. Thereafter the administrator or designee will do a random check monthly. The check will be documented and attached to this report. The checks will be kept in the facility.
Education: All med techs will be re educated by a certified medication trainer on the storage of OTC and CAM medications and the use of the check list. Education will take place 5/22/26 and will be attached to this report
QM: The violation and the progress of continued compliance of 185b will be reviewed at the next scheduled QM meeting of 06/03/2026. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented ([redacted] - 07/13/2026)

185a - Implement Storage Procedures

21. 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.

185a Implement Storage Procedures *(continued)*

Description of Violation

Resident #1 is currently prescribed Acetaminophen 500mg capsules Take 2 tablets by mouth every 8 hours as needed for pain; however, on 3/23/26, this medication was not present in the home and available for administration.

Plan of Correction ***Directed (- 05/18/2026)***

Immediate: Administrator contacted the facility pharmacy and ordered the Acetaminophen 500 mg tablets take 2 tablets by mouth every 8 hours as needed for pain for resident 1. It was delivered on 3/24/26
Continued compliance: Medication cart audit will be completed monthly and will begin May 2026. The audits will be completed by administrator or designee. (DIRECTED: The monthly audits shall begin on 6/1/26 and include a review of all resident medications to ensure all medications are present in the home and available for administration. 5/18/26). Medications (PRN or re orders) that are not on a cycle will be ordered from the facility pharmacy if there are less than a weeks supply left. A notebook of all order called or faxed to the pharmacy will be kept in the med cart.
Orders will be checked off when they are received . Any medication order not received in 48 hours will require a follow up call to the pharmacy. Notebook/Log of all orders called to the pharmacy will be kept in the med cart.
Education: Medication techs will be re educated om 185 a. Education will be done by a certified medication trainer. Training is scheduled for 5/22/26. Cart audit and implementation of the order book will begin 5/22/26. Education will include the use of the notebook to document orders phoned into the pharmacy, (DIRECTED: Documentation of the staff education will be kept. 5/18/26).
Random MAR audit will be completed by a designee to investigate any medication documented as not given refused, or not available. Results will be kept in the building. Random audit will begin 5/28/26 and will be completed by a certified medication trainer. Goal is to determine training needs and compliance. (DIRECTED: The audits shall be conducted with at least 3 different residents each week. 5/18/26).
Training needs or evidence o non compliance will be shared with the Administrator
QM: Violation, cart reviews, mar reviews, will be reviewed at the time of the next QM meeting scheduled for 06/03/2026. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

187d - Follow Prescriber's Orders

22. Requirements

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

Description of Violation

Resident #5 is currently prescribed Ozempic 4mg/3ml Inject 1mg into the skin every 7 days for diabetes. Resident #5 received this medication on 3/14/26; however, this medication was not administered to resident #5 on 3/21/26, because the medication was not available in the home for administration.

Plan of Correction ***Directed (- 05/18/2026)***

Immediate: Administrator contacted the prescriber for instruction as had not been contacted at the time of the missed medication. Orders were received and are included in this report. Medication was ordered from the

187d Follow Prescriber's Orders (continued)

pharmacy and received on 4/2/26 Medication was restarted (administered on 4/03/26) per physician orders. Documentation of the order and MAR will be attached to this report.
Continued Compliance: Med Cart/MAR Audit to take place monthly to include medications in the refrigerator. Orders not on cycle will be phoned to pharmacy and written in the order logbook.
Audit to be completed by certified medication trainer or a designee. Next audit to take place 6/1/26 (DIRECTED: The monthly audits shall include a review of all resident medications to ensure all medications are present in the home and available for administration. [redacted] 5/18/26).
Education: Med techs to be re educated in the medication cycle by a certified medication trainer. This includes ordering, and storage, documentation and the reporting to the prescriber and department for any medication not available to be given at the prescribed time. Training to take place 5/22/26/ Documentation will be kept in the home and attached to this report.
QM: The violation and the current compliance efforts will be reviewed at the nest QM meeting scheduled for 06/03/2026. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented ([redacted] - 07/13/2026)

188b - Medication Error Reporting

23. Requirements

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

Description of Violation

Resident #5 is currently prescribed Ozempic 4mg/3ml Inject 1mg into the skin every 7 days for diabetes. Resident #5 was not administered this medication on 3/21/26, because the medication was not available in the home for administration; however, this medication error was not reported to the prescriber until 3/27/26.

Plan of Correction ***Directed ([redacted] - 05/18/2026)***

Immediate: Administrator contacted the prescriber of the Ozempic on 3/24/26. [redacted] provided guidance as to restarting the medication on 3/28/26. The order and the MAR will be attached to this report.
The responsible party was also contacted and informed of the omission and update from the prescriber. Documentation will be attached to this report
Continued compliance: MAR audit will take place weekly times four weeks. Audit will reveal any medication documented as not available, refused or not given for any reason. Follow up will include documentation of the event to the prescriber and to the responsible part. MAR audits will begin 6/1/26 and will be completed by a certified trainer or designee.
Education: All med techs will be re educated on the requirement of a a missed medication ie; notify prescriber and responsible party and submit a reportable incident. Education will take place 5/22/26
QM: Violation and related requirement of mediations not given will be reviewed and evaluated for current compliance. QM meeting scheduled for 06/03/2026. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 5/18/26)

188b Medication Error Reporting (continued)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/13/2026)

225c - Additional Assessment

24. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #2's most recent assessment, dated , indicates resident #2 is independent in managing finances; however, since September, 2024, resident #2 has had a representative payee and does not manage their own finances.

REPEAT VIOLATION: 11/17/2025

Plan of Correction ***Directed (- 05/18/2026)***

1Immediate ACtion: Administrator/owner reviewed the assessment of resident #2 dated Resident number 2 has a representative payee for rent and other obligations but handles their spending money independently. The assessment was amended to include the Rep Payee (Payee Services) and initialed by the Administrator and resident #2. It will be attached to this report
Continued compliance: The Administrator/owner or designee will audit all assessments to ensure the accuracy of 225c. Audit will be completed by 5/30/26.
Thereafter the administrator or designee will randomly audit 5 assessment per month including the most recent admission to ensure compliance with 225c Monthly audits will begin 5/30/26 and will be completed by the administrator or the designee. They will be available in the home.
Audits will be attached to this report and kept in the facility
QM: The violation, audits and compliance improvement will be reviewed at the next QM meeting (UNACCEPTABLE TIMEFRAME 5/18/26. DIRECTED: By 6/3/26: The administrator shall conduct a quality management review, which includes a review of all items specified in 2600.26b. Documentation of the review shall be kept. 5/18/26)

Proposed Overall Completion Date: 06/03/2026

Directed Completion Date: *06/03/2026*

Implemented (- 07/14/2026)