pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ALWAYS ON CARE LLC**
LEGAL ENTITY

To operate **ALWAYS ON CARE**
NAME OF FACILITY OR AGENCY

Located at **600 NORTH LAUREL STREET, HAZELTON, PA 18201**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **26**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **May 21, 2026** until **May 21, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **230060**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: June 2, 2026

[redacted]
Owner
Always On Care LLC
[redacted]

RE: Always On Care LLC
600 North Laurel Street,
Hazelton, Pennsylvania, 18201
License: 230060

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on March 25, 2026, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

May 28, 2026

[redacted]
ALWAYS ON CARE LLC
[redacted]

RE: ALWAYS ON CARE
600 NORTH LAUREL STREET
HAZELTON, PA, 18201
LICENSE/COC#: 23006

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/25/2026 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ALWAYS ON CARE* **License #:** *23006* **License Expiration:** *05/21/2026*

Address: *600 NORTH LAUREL STREET, HAZELTON, PA 18201*

County: *LUZERNE* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *ALWAYS ON CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *08/08/2022* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *20* **Waking Staff:** *15*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *03/25/2026*

Inspection Dates and Department Representative

03/25/2026 - 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: *0*

Number of Residents Who:

Receive Supplemental Security Income: *14* **Are 60 Years of Age or Older:** *18*

Diagnosed with Mental Illness: *16* **Diagnosed with Intellectual Disability:** *1*

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

Inspections / Reviews

03/25/2026 - Full

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

04/22/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/04/2026*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/27/2026*

Inspections / Reviews *(continued)*

04/29/2026 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/04/2026*

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

05/26/2026 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/04/2026*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

At 9:15A.M., the License inspection summary's from [redacted] and [redacted] were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 04/22/2026)***

Responsible Person: Administrator

On 03/25/2026, the Administrator immediately printed and posted the most recent Licensing Inspection Summaries (including 10/16/25 and 8/28/25) along with the current license in a clearly visible and public location in the main hallway of the home.

Beginning 03/26/2026, the Administrator will maintain a Licensing Posting Checklist, ensuring that:

Current license
Current LIS
Chapter 2600 regulations

are posted at all times.

On 04/01/2026, all supervisory staff were trained to verify postings during weekly walkthroughs.

Monitoring:
The Administrator will verify postings weekly every Monday starting 04/01/2026 and document compliance in a Log.

Licensee's Proposed Overall Completion Date: *04/19/2026*

Implemented [redacted] - 05/26/2026)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

At approximately 9:40 a.m. in the 2nd floor men's bathroom, the toilet had a brown fecal like substance on the toilet seat and the shower curtain had a black mold-like substance on the right side.

At approximately 10:15 a.m. in the kitchen, the outside door and frame area of the upper oven had an unknown hard, crusty substance on it, and the inside of the lower oven contained large crumbs and unknown burnt on food substances.

At approximately 10:15 a.m. in the kitchen, the upper cabinet by the sink area had a white powder substance on the 2nd shelf and the baking powder container was sticky and also covered in the white powder substance.

85a - Sanitary Conditions (continued)

At 9:45 a.m., ¼ of the surface of the shower curtain hanging in the 2nd floor shared men's bathroom was coved in spots of a black substance resembling mildew.

At 9:47 a.m. ¼ of the surface of the shower curtain hanging in the 2nd floor shared women's bathroom was covered in a black substance resembling mildew.

At 9:55 a.m. the shower curtain hanging in the shared bathroom near room 4 was observed to have 2 pea sized spots of a dried reddish brown substance resembling blood on the right section of the shower curtain.

Repeated Violation-[redacted] et al.,[redacted] et al.

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

Responsible Person: Administrator / Housekeeping Supervisor

On 03/25/2026, the Administrator and housekeeping staff immediately performed a full deep cleaning of:

All bathrooms (including removal of fecal matter and mold-like substances)
All shower curtains (replaced where necessary)
Kitchen appliances (ovens cleaned and sanitized)
Cabinets and food storage areas

All contaminated materials were either sanitized or discarded the same day.

Beginning 03/26/2026, the home implemented a Daily Cleaning Schedule and Sanitation Checklist, requiring:

Bathrooms cleaned twice daily
Kitchen cleaned after each meal
Weekly deep cleaning of appliances

On 03/30/2026, all staff received retraining on sanitation standards.

Monitoring:
The Administrator will conduct weekly sanitation audits every Friday starting 04/04/2026, and staff will conduct daily checks.

Licensee's Proposed Overall Completion Date: *04/19/2026*

Implemented [redacted] - 05/26/2026)

85d - Trash Receptacles

3. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

85d - Trash Receptacles *(continued)*

Description of Violation

At 9:35 a.m. there was a full, uncovered, unattended trash can in the shared bathroom near room [redacted].

Plan of Correction ***Accept [redacted] - 04/22/2026)***

Responsible Person: Administrator

On 03/25/2026, the uncovered trash receptacle was immediately replaced with a covered, insect-resistant trash can.

Beginning 03/26/2026, all bathrooms and kitchen areas were equipped with covered receptacles, and staff were instructed to ensure lids remain closed.

On 03/30/2026, staff were retrained on sanitation and pest prevention procedures.

Monitoring:
Staff will check all trash receptacles daily, and the Administrator will verify compliance weekly starting 04/01/2026.

Licensee's Proposed Overall Completion Date: *04/19/2026*

Implemented [redacted] - 05/26/2026)

95 - Furniture and Equipment

4. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

At approximately 10:50 a.m. the homes fire alarm panel was observed to be open and the circuit board was visible. The system's notification lights were lit to indicate Trouble, Silenced and Line Fault. Staff of the home indicated the alarm panel had been displaying the message for some time, and noted the panel was last inspected in January of 2026.

Plan of Correction ***Accept [redacted] 04/22/2026)***

Responsible Person: Administrator

On 03/25/2026, the Administrator immediately contacted the fire alarm company to evaluate the system.

On 03/25/2026, the company indicated that the system is old, not needed, and the prior technician forgot to deactivate the nonworking system.

On 4/14/26 a licensed technician inspected the old system ensuring that the panel was correctly deactivated, secured, and closed, and that the new system was fully operational.

Documentation of check-up was obtained and placed on file.

Beginning 04/01/2026, the Administrator will:

Maintain a Fire System Maintenance Log
Ensure monthly inspections are documented

95 - Furniture and Equipment (continued)

Monitoring:
The Administrator will review system status weekly starting 04/01/2026 and confirm quarterly vendor inspections.

Licensee's Proposed Overall Completion Date: *04/19/2026*

Implemented [redacted] - 05/26/2026)

101j7 - Lighting/Operable Lamp

5. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

At approximately 11:20 a.m. in room [redacted], resident #[redacted] did not have a source of light that can be turned on/off at bedside.

Repeated Violation-[redacted], et al.

Plan of Correction ***Accept [redacted] - 04/22/2026)***

Responsible Person: Administrator

On 03/25/2026, an operable bedside lamp was immediately placed in Resident #2's room.

Beginning 03/26/2026, all rooms were inspected to confirm compliance.

On 04/01/2026, a Room Setup Checklist was implemented to ensure all required furnishings are present.

Monitoring:
The Administrator will complete monthly room audits starting 04/01/2026.

Licensee's Proposed Overall Completion Date: *04/19/2026*

Implemented [redacted] - 05/26/2026)

103e - Left Overs

6. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At approximately 10:15 a.m. the lower oven in the kitchen area had 3 pieces of toast on a metal tray that was not labeled or dated.
At approximately 10:15 a.m. in the crisper drawer of the kitchen refrigerator there was a packet of graham cracker crumbs that was not labeled or dated.
At approximately 10:15 a.m. in the upper cabinet by the sink area in the kitchen, there was a pack of Goya Rice that was not dated.

103e - Left Overs *(continued)*

Plan of Correction ***Accept [redacted] - 04/22/2026)***

Responsible Person: Staff

On 03/25/2026, all unlabeled food items were immediately discarded.

Beginning 03/26/2026, all food items are required to be:

Labeled
Dated

On 03/30/2026, kitchen staff were retrained.

Monitoring:
The staff will check labeling daily, and the Administrator will audit weekly starting 04/01/2026.

Licensee's Proposed Overall Completion Date: *04/19/2026*

Implemented [redacted] - 05/26/2026)

103f - Refrigerator/Freezer Temps

7. 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

At approximately 9:45 a.m. in the pantry area, the temperature of freezer #5 was 3 degrees Fahrenheit and the temperature of freezer #6 was 8 degrees Fahrenheit.
At approximately 10:15 a.m. in the kitchen area, the temperature of the freezer was 12 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 04/22/2026)***

Responsible Person: Administrator

On 03/25/2026, freezer temperatures were adjusted to meet required standards.

On 03/26/2026, all units were rechecked and verified compliant.

Beginning 04/01/2026, a Temperature Log was implemented requiring:

Weekly checks

Monitoring:
The Administrator will record temps weekly.

Licensee's Proposed Overall Completion Date: *04/19/2026*

Implemented [redacted] - 05/26/2026)

103g - Storing Food

8. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At approximately 10:15 a.m. in the lower cabinet by the sink in the kitchen area there was a 1-gallon container of vegetable oil that did not have a lid on it.

Repeated Violation [redacted], et al.

Plan of Correction ***Accept [redacted] - 04/29/2026)***

Responsible Person: Staff

On 03/25/2026, the uncovered oil container was immediately sealed with a proper lid.

Beginning 03/26/2026, all food items must be stored in sealed containers.

Staff retrained on 03/30/2026.

Monitoring:
Weekly checks and audits by Administrator.

Licensee's Proposed Overall Completion Date: *04/27/2026*

Implemented ([redacted] - 05/26/2026)

103i - Outdated Food

9. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At 9:50 a.m. a dented can of chef's quality peas and 5 dented cans of chef's quality cut yams were observed in the pantry of the home.

Plan of Correction ***Accept [redacted] - 04/29/2026)***

Responsible Person: Administrator
On 03/25/2026, the Administrator immediately corrected the violation by discarding or properly securing the uncovered 1-gallon container of vegetable oil with a tight-fitting lid. On the same date, the Administrator inspected all food storage areas in the kitchen to ensure that all food items were stored in closed or sealed containers, and any non-compliant items were corrected immediately.
Beginning 03/26/2026, the Administrator implemented a Food Storage Compliance Procedure, which requires:
• All food items (including oils, dry goods, and opened products) to be stored in sealed, covered, or lidded containers at all times
• Immediate correction of any uncovered food items upon identification
• Inspection of all food storage areas at the start and end of each shift
On 03/30/2026, all kitchen and direct care staff were retrained on proper food storage requirements under §2600.103(g), including hands-on demonstration of proper sealing and storage procedures.
To ensure this violation does not recur, beginning 04/01/2026, the Administrator implemented a Daily Kitchen

103i - Outdated Food (continued)

Sanitation and Food Storage Log, which includes:
• Verification that all food containers are sealed
• Initials of staff completing each check
• Documentation of any corrections made
Monitoring:
The Administrator will conduct and document daily inspections (each shift) using the Food Storage Log beginning 04/01/2026.
The Administrator will review the log and conduct weekly unannounced kitchen audits every Friday 04/27/2026 -5/31/2026 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *04/27/2026*

Implemented [redacted] - 05/26/2026)

141a 1-10 Medical Evaluation Information

10. 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

The medical evaluation dated [redacted] for resident [redacted] does not include a determination by the physician if resident's needs can be met in the personal care home or if the resident requires a skilled nursing facility.

Repeated Violation [redacted], et al.

Plan of Correction ***Accept [redacted] - 04/29/2026)***

Responsible Person: Administrator
On 03/27/2026, the Administrator immediately corrected the violation by obtaining a completed and updated medical evaluation for Resident #3 from the physician, which now includes a documented determination that the resident's needs can be met in a personal care home setting. The corrected evaluation was placed in the resident's record on the same date.
On 03/26/2026, the Administrator conducted a full audit of all current resident medical evaluations to ensure that each evaluation included all required elements under §2600.141(a), including the physician's determination regarding level of care. Any incomplete records identified were corrected immediately.
Beginning 03/30/2026, the Administrator implemented a Medical Evaluation Review Checklist, which requires verification of all required components, including:

141a 1-10 Medical Evaluation Information (continued)

• Physician determination of appropriate level of care
• Complete medical, medication, and mobility information
• Confirmation that the home can meet the resident's needs
Beginning 04/01/2026, all new admissions and updated evaluations will be reviewed for completeness prior to acceptance or filing, and no resident will be admitted or retained without a fully completed medical evaluation.
On 03/30/2026, all administrative and supervisory staff were retrained on medical evaluation requirements and documentation standards under §2600.141(a).
To ensure this violation does not recur, the Administrator implemented a Weekly Resident Record Audit System beginning 04/01/2026, which includes:
• Review of all new and updated medical evaluations
• Verification of physician level-of-care determination
• Immediate correction of any deficiencies
Monitoring:
The Administrator will review all medical evaluations upon receipt and prior to filing beginning 04/01/2026 using the Medical Evaluation Checklist.
The Administrator will conduct and document weekly chart audits every Monday starting 04/27/2026 -5/31/2026 to ensure all evaluations remain complete and compliant.

Licensee's Proposed Overall Completion Date: *04/27/2026*

Implemented [redacted] - 05/26/2026)

144c1 - Smoking Area Guidelines

11. 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

At approximately 9:30 a.m. in the smoking area of the facility located in the patio area, there were approximately 20 cigarette butts on the ground next to the smoking receptable by the table and chairs and approximately 40 cigarette butts on the ground next to the smoking receptacle located on the grass. In addition, the smoking receptable located on the grass was overflowing with cigarette butts and was not usable.

Plan of Correction ***Accept [redacted] - 04/22/2026)***

Responsible Person: Administrator

On 03/25/2026, the Administrator immediately corrected the violation by ensuring that the smoking area was fully cleaned and restored to a safe condition. All cigarette butts located on the ground in both designated smoking areas were removed, and the overflowing smoking receptacle was emptied, cleaned, and returned to proper working condition the same day. The Administrator also verified that all smoking receptacles were fireproof, properly placed, and fully usable.

Beginning 03/26/2026, the Administrator implemented a Smoking Area Maintenance and Fire Safety Procedure,

144c1 - Smoking Area Guidelines (continued)

which includes:

Designated smoking areas clearly identified and maintained
Daily emptying of all smoking receptacles
Immediate removal of cigarette debris from the ground
Verification that receptacles are not overflowing and remain usable
Availability of fire-safe ashtrays and receptacles at all times

On 03/30/2026, all direct care staff were retrained on smoking area supervision, fire safety expectations, and their responsibility to monitor residents using the smoking area and ensure proper disposal of smoking materials.

To ensure this violation does not recur, beginning 04/01/2026, the Administrator implemented a Daily Environmental and Fire Safety Checklist, which includes specific review of:

Cleanliness of smoking areas
Proper use and condition of fireproof receptacles
Absence of cigarette debris on the ground
Compliance with fire safety standards

Monitoring:
The Direct Care Staff (Designee on Duty) will monitor the smoking area each shift to ensure cleanliness and proper use. The Administrator will conduct and document weekly environmental and fire safety audits every Friday starting 04/04/2026 to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/19/2026*

Implemented [redacted] 05/26/2026)

181c - Self-administration Assessment

12. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident [redacted] self-administers medications to include [redacted] however, resident [redacted] has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications. The resident's most recent medical evaluation dated [redacted] stated the resident cannot self-administer medications and the resident does not have a current order to self-administer the medication.

Plan of Correction ***Accept [redacted] - 04/29/2026)***

Responsible Person: Administrator
On 03/25/2026, the Administrator immediately corrected the violation by stopping Resident #1 from self-administering medications, including Copaxone, due to lack of physician authorization. The medication was secured, and all doses were administered by trained staff beginning that same day.

181c - Self-administration Assessment (continued)

On 03/27/2026, the Administrator obtained a physician-completed assessment confirming whether the resident is able or unable to self-administer medications and whether reminders are required. The updated physician documentation was placed in the resident's record and reviewed for compliance.
On 03/27/2026, the Administrator updated the resident's assessment and support plan to reflect the physician's determination regarding medication administration and supervision needs.
On 03/27/2026, the Administrator conducted a full audit of all residents to ensure that any resident self-administering medications has:
• A physician order authorizing self-administration
• A completed assessment of ability to self-administer
• Proper documentation in the support plan
Any discrepancies identified were corrected immediately.
Beginning 03/30/2026, the Administrator implemented a Medication Self-Administration Verification Procedure, which requires:
• No resident may self-administer medications without physician authorization and documented assessment
• All self-administration approvals must be verified and documented in both the medical record and support plan
• Medications must be secured unless authorized for self-administration
On 03/30/2026, all direct care and supervisory staff were retrained on medication administration requirements under §2600.181(c), including:
• Identification of authorized vs. unauthorized self-administration
• Proper handling of injectable medications
• Documentation and supervision requirements
To ensure this violation does not recur, 04/27/2026 -5/31/2026, the Administrator implemented a Weekly Medication Compliance Audit, which includes:
• Verification of physician orders for self-administration
• Review of support plans for consistency
• Confirmation that no resident is self-administering without authorization
Monitoring:
The Administrator will verify all medication administration statuses upon admission and upon any physician order update beginning 04/01/2026.
The Administrator will conduct and document weekly medication audits every Monday starting 04/27/2026 -5/31/2026, including direct observation of medication practices to ensure compliance.

Licensee's Proposed Overall Completion Date: *04/27/2026*

Implemented [redacted] - 05/26/2026)

182c - Medication Administration

13. Requirements

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

Description of Violation

At 12:05 P.M., staff person A placed a prescribed medication [redacted] tablet in resident [redacted] hand at the dining room table. However, staff person A did not watch resident [redacted] ingest the medication before walking away from the resident. Resident [redacted] does not have an order to self-administer medication.

182c - Medication Administration *(continued)*

Plan of Correction ***Accept (- 04/29/2026)***

Responsible Person: Administrator
On 03/25/2026, the Administrator immediately corrected the violation by providing one-on-one retraining to Staff Person A, specifically instructing that all medications must be administered and observed until fully ingested before leaving the resident. The Administrator also conducted direct observation of a full medication pass on the same date to ensure proper administration practices were followed.
On 03/25/2026, the Administrator reviewed Resident #1's record and confirmed that the resident does not have authorization to self-administer medications, and therefore must be directly supervised during all medication administration.
On 03/26/2026, the Administrator conducted a facility-wide observation of medication passes across all shifts to ensure all staff were properly observing ingestion. Any deficiencies were corrected immediately.
Beginning 03/30/2026, the Administrator implemented a Medication Administration Procedure, which requires:
• Staff must remain with the resident until the medication is visually confirmed as ingested
• No medication may be left unattended with a resident
• Any refusal or delay must be documented immediately on the MAR
• Staff must not leave the medication area until administration is complete
On 03/30/2026, all direct care staff were retrained and competency-tested on medication administration requirements under §2600.182(c), including proper observation techniques and documentation standards.
To ensure this violation does not recur, beginning 04/27/2026, the Administrator implemented a Medication Pass Observation Log, which includes:
• Random observation of medication passes
• Documentation of staff compliance with ingestion observation
• Immediate corrective action if deficiencies are identified
Monitoring:
The Medication Supervisor will conduct and document random medication pass observations on each shift beginning 04/27/2026 - 5/31/2026.
The Administrator will conduct and document weekly unannounced medication audits every Monday starting 04/27/2026 - 5/31/2026, including direct observation of staff administering medications to ensure full compliance.

Licensee's Proposed Overall Completion Date: *04/27/2026*

Implemented - 05/26/2026)

183e - Storing Medications

14. 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

At 2:10 P.M., resident s was located in the home's mediation cart. However, the medication did not document a date when the medication was first opened. According to the manufacturer's instructions the medication needs to be used with 28 days of opening.

Plan of Correction ***Accept - 04/29/2026)***

Responsible Person: Administrator

183e - Storing Medications (continued)

On 03/25/2026, the Administrator immediately corrected the violation by labeling Resident [redacted] pen with the date opened and verifying that the medication was within the manufacturer's 28-day usage period.

On the same date (03/25/2026), the Administrator conducted a full audit of all medication carts and storage areas, including refrigerated medications, to ensure that:

• All opened medications requiring dating (including insulin, eye drops, and liquids) were properly labeled

• Any medications without open dates were either correctly labeled based on verified start date or discarded if the date could not be confirmed

Beginning 04/27/2026, the Administrator implemented a Medication Dating and Expiration Control Procedure, which requires:

• All medications requiring an open date to be labeled immediately upon opening

• Staff to verify open dates at the time of each medication pass

• Immediate removal and disposal of medications that exceed manufacturer guidelines (e.g., insulin beyond 28 days)

On 03/30/2026, all direct care and medication administration staff were retrained and competency-tested on proper medication storage requirements under §2600.183(e), including:

• Manufacturer-specific storage and expiration requirements

• Proper labeling procedures

• Identification of medications requiring open-date tracking

To ensure this violation does not recur, beginning 04/27/2026, the Administrator implemented a Medication Storage and Dating Log, which includes:

• Daily verification that all applicable medications are properly dated

• Documentation of any corrections made

• Initials of staff completing the check

Monitoring:

The Medication Supervisor will conduct and document daily medication cart checks (each shift) beginning 04/27/2026, verifying open dates and expiration compliance.

The Administrator will conduct and document weekly unannounced medication audits every Monday starting 04/27/2026 – 5/31/2026, including random review of high-risk medications such as insulin to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/27/2026*

Implemented [redacted] 05/26/2026)

185a - Implement Storage Procedures

15. 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] has an order for [redacted] PRN. However, this medication was not available in the home.

Repeated Violation-[redacted], et al.

Plan of Correction ***Accept [redacted] - 04/29/2026)***

Responsible Person: Administrator

185a - Implement Storage Procedures (continued)

On 03/25/2026, the Administrator immediately corrected the violation by verifying the availability of Resident [redacted] PRN medication ([redacted]) in the medication cart. The medication was confirmed present, properly labeled, and accessible for administration. On the same date, the Administrator conducted a full audit of all resident medications, including PRN medications, to ensure that all ordered medications were physically present, correctly stored, and available for use.

Beginning 03/26/2026, the Medication Supervisor implemented a Medication Inventory and Availability Procedure, which requires:

• Verification at the start of each shift that all scheduled and PRN medications are present in the medication cart

• Immediate notification to the Administrator and pharmacy if any medication is missing, low in quantity, or unavailable

• Reordering of medications at least 3–5 days prior to depletion to prevent gaps in availability

On 03/30/2026, all medication administration staff were retrained and competency-tested on medication storage, access, and availability requirements under §2600.185(a), including:

• Responsibility to ensure medications are present before administration times

• Procedures for reporting missing medications

• PRN medication availability requirements

To ensure this violation does not recur, beginning 04/27/2026, the Administrator implemented a Daily Medication Inventory Log, which includes:

• Verification of all medications, including PRNs, being present and available

• Documentation of medication counts for critical medications

• Immediate documentation and action for any discrepancies

Monitoring:

The Medication Supervisor will complete and document medication inventory checks at the beginning of each shift starting 04/27/2026 until 5/31/2026, ensuring all medications, including PRNs, are available.

The Administrator will conduct and document weekly unannounced medication audits every Monday starting 04/27/2026 until 5/31/2026, including verification of PRN medication availability and review of reorder logs to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *04/27/2026*

Implemented [redacted] 05/26/2026)

224a - Preadmission Screen Form

16. 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]'s 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 ***Accept [redacted] - 04/29/2026)***

Responsible Person: Administrator

On 03/26/2026, the Administrator immediately corrected the violation by completing and documenting a proper determination on Resident [redacted]'s preadmission screening form confirming that the resident's needs can be met by

224a - Preadmission Screen Form (continued)

the services provided by the home. The updated form was placed in the resident's record on the same date.
On 03/26/2026, the Administrator conducted a full audit of all current resident preadmission screening forms to ensure that each form included a documented determination that the resident's needs can be met by the home. Any incomplete forms identified were corrected immediately.
Beginning 04/27/2026, the Administrator implemented a Preadmission Screening Verification Procedure, which requires:
• Completion of the Department's preadmission screening form in full, including the final determination of appropriateness for admission
• Verification that the home can meet all identified needs, including behavioral, medical, and supervision requirements
• Review and approval of the screening by the Administrator prior to admission
Beginning 04/27/2026, no resident will be admitted to the home without a completed and signed preadmission screening form that includes the required determination. The Administrator will serve as the final approval authority before any admission is accepted.
On 04/24/2026, all administrative and supervisory staff involved in admissions were retrained on preadmission screening requirements under §2600.224(a), including documentation standards and decision-making criteria.
To ensure this violation does not recur, beginning 04/27/2026, the Administrator implemented an Admission Checklist, which includes:
• Verification of completed preadmission screening form
• Confirmation of determination that needs can be met
• Signature of Administrator prior to admission
Monitoring:
The Administrator will review all preadmission screening forms at the time of completion and prior to admission beginning 04/27/2026 using the Admission Checklist.
The Administrator will conduct and document weekly resident record audits every Monday starting 04/27/2026 until 5/31/26, including verification that all preadmission screening forms are complete and compliant.

Licensee's Proposed Overall Completion Date: *04/27/2026*

Implemented ([redacted] - 05/26/2026)