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

July 23, 2026

[redacted], OWNER
PHILLIPSBURG SNF OPCO LLC
[redacted]

RE: HERITAGE RIDGE SENIOR LIVING AT WINDY HILL
250 DOGWOOD DRIVE
PHILIPSBURG, PA, 16866
LICENSE/COC#: 23281

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/31/2026, 04/06/2026 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: *HERITAGE RIDGE SENIOR LIVING AT WINDY HILL* **License #**: *23281* **License Expiration**: *02/10/2027*

Address: *250 DOGWOOD DRIVE, PHILIPSBURG, PA 16866*

County: *CENTRE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *PHILLIPSBURG SNF OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *03/03/2006* **Issued By**: *Williams Inspection Svc.*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *15* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/10/2026*

Inspection Dates and Department Representative

03/31/2026 - On-Site: [redacted]

04/06/2026 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *16* **Residents Served**: *14*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *14*

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

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

03/31/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/30/2026*

04/30/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/13/2026*

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

Inspections / Reviews *(continued)*

05/11/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/13/2026*

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

07/23/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/13/2026*

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

On 1/24/26 at 8:00 a.m. and 5:00 p.m. Resident #1 did not receive their prescribed Eliquis 2.5 mg, this was not reported to the Department until 1/26/26 at 2:00 p.m.

Repeat violation: 1/13/26

Plan of Correction ***Accept (- 04/28/2026)***

Staff will be educated and trained on the proper techniques and procedures required for appropriate reporting of medication errors, missing dosage, etc. by Administrator, [redacted] to include how to properly submit incident reports to the Department of Human Services by 5/1/2026 (See Attached). Weekly audits will be completed by the Administrator, [redacted] starting 4/20/2026 for a period of 2 months to ensure compliance with the regulatory requirements. Findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations.

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

Implemented (- 05/22/2026)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The home did not have the flu poster posted as required by the Influenza Awareness Act.

Plan of Correction ***Accept (- 04/28/2026)***

The flu poster has been posted on the bulletin by Administrator, [redacted] as of 4/1/2026. Continued monitoring of required publications will be ongoing throughout the community. (Photo Attached)

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

Implemented (- 05/22/2026)

63a - First Aid/CPR Training

3. Requirements

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

63a - First Aid/CPR Training *(continued)*

Description of Violation

On 3/21/26 and 3/22/26 there were 14 residents in the home, there was no First Aid/CPR trained staff working in the home from 11:00 p.m. – 7:00 a.m.

Repeat violation: 3/18/25

Plan of Correction ***Accept (- 04/28/2026)***

All staff members will be recertified in CPR and First Aid 5/1/2026. A certified CPR and First Aid staff member has been scheduled on each shift since 3/31/2026. Employee records will be audited monthly for three months by Administrator, [redacted] to ensure they are up to date with all regulatory requirements starting 4/29/2026. Findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations. Findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations.

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

Implemented (- 05/22/2026)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff person A, hired [redacted] completed their first 40 hours of work prior to [redacted], did not receive training in the emergency medical plan.

Plan of Correction ***Accept (- 04/28/2026)***

The required training is conducted with new staff members the first week of training. (See Attached) The identified staff member "A" has been re-educated and all future staff member education going forward there will be a required to sign a acknowledgement form stating they received training in the Emergency Medical Plan prior to their first 40 hours of work. Administrator, [redacted] will audit monthly to ensure all documentation and trainings are up to date starting 5/1/2026. Findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations

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

Implemented (- 05/22/2026)

65i - Training Record

5. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The training record provided for staff training on 7/30/25 does not indicate the length of each course.

Plan of Correction ***Accept (- 04/28/2026)***

Training records (sign-in sheets) from this point forward will contain the length of the course for each course

65i - Training Record (continued)

presented. Administrator, [redacted] will audit monthly for three months to ensure all trainings include the required information. Findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations. Findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations.

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

Implemented ([redacted] - 05/22/2026)

82a - Poisonous Materials

6. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

At approximately 9:15 a.m. in the laundry room there was an unlabeled yellow spray bottle with a chemical smell. The administrator identified the liquid as Shout. The spray bottle did not have a manufacturer's label on it.

Plan of Correction ***Accept ([redacted] - 04/28/2026)***

The unlabeled bottle was removed from the laundry room by Administrator, [redacted] as of 3/31/2026. Staff will be educated on the storage of poisonous materials by 5/1/2026 by Administrator, [redacted] Monthly audits will be performed by Administrator, [redacted] to ensure proper storage of poisonous materials. Findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations.

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

Implemented ([redacted] - 05/22/2026)

121a - Unobstructed Egress

7. 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

At approximately 9:01 a.m., patio furniture which was located outside the double doors near room 530 blocked egress from the home's interior hallway to the patio.

Plan of Correction ***Accept ([redacted] - 04/28/2026)***

Patio furniture was removed from outside the double doors near room 530. Administrator, [redacted] will educate staff on all three shifts on the importance of blocking doors that provide immediate egress. DES will audit this area for any blockage of egress daily for three months. Findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations.

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

Implemented ([redacted] - 05/22/2026)

132b - Safety Inspection/Fire Drill

8. Requirements

2600.

132b - Safety Inspection/Fire Drill *(continued)*

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The facility has not had a fire safety inspection completed by a fire safety expert since 6/5/2024.

Plan of Correction ***Accept (- 05/11/2026)***

An annual fire safety inspection was conducted on 9/11/2025; however, the documentation was misplaced prior to the most recent Department of Human Services survey on 3/31/2026. As of 5/8/2026, DES contacted the local fire company, and the Fire Chief completed a replacement inspection form for documentation purposes. Going forward, DES and the Administrator, [redacted] will maintain copies of all fire safety inspection forms to prevent future occurrences. DES will conduct monthly audits for three months beginning 6/1/2026, to ensure all inspection forms are completed fully and on time.

Licensee's Proposed Overall Completion Date: *05/08/2026*

Implemented (- 05/22/2026)

132c - Fire Drill Records

9. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drills conducted on 8/29/25 at 11:04, 10/31/25 at 6:40, 2/31/25 at 3:52 and 3/31/26 at 7:30 do not indicate a.m. or p.m.

The fire drills conducted on 3/26/25, 4/25/25, 5/29/25, 7/15/25, 8/29/25, 9/30/25, 10/31/25, 11/25/25, 12/31/25, 1/30/26, and 2/27/26 do not indicate an evacuation time in minutes and seconds.

The homes is licensed for 16 residents. The home is inaccurately recording the number of residents and staff participating in the fire drills by combining the personal care residents and staff along with the skilled nursing residents and staff. The fire drill log on 3/26/25 indicates 87 residents and 38 staff. The fire drill log on 4/25/25 indicates 86 residents and 28 staff. The fire drill log on 5/29/25 indicates 87 residents and 36 staff. The fire drill log on 6/18/25 indicates 89 residents and 34 staff. The fire drill log on 7/15/25 indicates 88 residents and 13 staff. The fire drill log on 8/29/25 indicates 87 residents and 34 staff. The fire drill log on 9/30/25 indicates 86 residents and 30 staff. The fire drill log on 10/31/25 indicates 94 residents and 23 staff. The fire drill log on 11/25/25 indicates 84 residents and 37 staff. The fire drill log on 12/31/25 does not indicate the number of residents and 19 staff. The fire drill log on 1/30/26 indicates 14 residents and does not indicate the number of staff. The fire drill log on 2/27/26 indicates 84 residents and 34 staff. This does not accurately reflect the number of personal care residents and personal care staff that participated in the fire drill.

132c - Fire Drill Records (continued)

Plan of Correction ***Accept (- 05/11/2026)***

A fire drill was conducted on 3/31/2026. Effective that date, the DES Supervisor began using the fire drill documentation form provided by the Department of Human Services, which will be utilized for all future drills. Beginning 3/31/2026, DES will document the number of residents in Personal Care and the total evacuation time, and will ensure that exit routes are alternated during drills. The DES Supervisor will audit these forms monthly for a period of five months, beginning 5/1/2026, to ensure ongoing regulatory compliance

Licensee's Proposed Overall Completion Date: *05/08/2026*

Implemented (- 05/22/2026)

132d - Evacuation

10. 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 homes most recent letter from a fire safety expert designating a safe evacuation time based on the construction of the building was completed on 9/11/25 noting a safe evacuation time of 4 minutes and 48 seconds. The previous letter was completed on 6/5/24 noting a safe evacuation time of 4 minutes and 40 seconds.

The following fire drills exceeded the safe evacuation time: On 3/26/25 at 3:58 p.m. the homes evacuation time was 7 minutes. On 4/25/25 6:18 a.m. the homes evacuation time was 6 minutes. On 6/18/25 at 10:30 a.m. the homes evacuation time was 30 minutes. On 7/15/25 at12:28 a.m. the homes evacuation time was 7 minutes. On 8/29/25 at 11:04 the homes evacuation time was 4 minutes. On 9/30/25 at 3:10 p.m. the homes evacuation time was 5 minutes. On 10/31/25 at 6:40 the homes evacuation time was 21 minutes. On 12/31/25 the homes evacuation time was 10 minutes. On 1/30/26 at 5:15 a.m. the homes evacuation time was 10 minutes. On 2/27/26 the homes evacuation time was 9 minutes.

Plan of Correction ***Accept (- 05/11/2026)***

Staff across all three shifts received education on safe evacuation times on 4/24/2026 (see attachment). DES will track and monitor evacuation times using the form provided by the Department of Human Services. The Administrator, in collaboration with DES, will ensure that safe evacuation times are consistently met. DES will conduct monthly audits for three months beginning 5/1/2026. Evacuation time data will be monitored and reported to the Quality Assurance and Performance Improvement (QAPI) Committee for oversight.

Licensee's Proposed Overall Completion Date: *05/08/2026*

132d Evacuation *(continued)*

Implemented (- 05/22/2026)

132g Fire Drills Days/Times

11. 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 fire drills conducted from 3/26/25 through 2/27/26 were held within the last 15 days of the month.

Plan of Correction ***Accept (- 05/11/2026)***

Going forward, DES will conduct fire drills on a more randomized and evenly distributed schedule. Beginning 6/1/2026, DES will ensure that a fire drill is conducted prior to the final 15 days of each month. To ensure compliance, DES will audit fire drill dates and times monthly for a three-month period beginning 5/1/2026

Licensee's Proposed Overall Completion Date: *05/08/2026*

Implemented (- 05/22/2026)

141a Medical Evaluation

12. 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.

Description of Violation

Resident #2 was admitted to the home on The resident did not have a medical evaluation completed.

Plan of Correction ***Accept (- 05/11/2026)***

A DME for Resident #2 was completed by a Medication Technician and signed by a physician on 4/30/2026 (see attachment). The Administrator, will conduct monthly audits for three months beginning 5/1/2026, to ensure all residents have current DMEs. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and any further recommendations.

Licensee's Proposed Overall Completion Date: *05/08/2026*

Implemented (- 05/22/2026)

141b1 Annual Medical Evaluation

13. 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 was signed by the resident's physician on The annual medical evaluation does not include the resident's height, the date the resident was evaluated, and if the resident's needs can

141b1 Annual Medical Evaluation (continued)

be met in the personal care home

Repeat violation: 1/13/26, 3/18/25

Plan of Correction ***Accept (- 05/11/2026)***

Resident #3 had a DME completed by a physician on 4/21/2026, which includes the resident's height, date of evaluation, and confirmation that the resident's needs can be met in a personal care home (see attachment). The Administrator, will conduct monthly audits for three months beginning 5/1/2026, to ensure all DMEs are current and completed in their entirety.

Licensee's Proposed Overall Completion Date: *05/08/2026*

Implemented (- 07/23/2026)

144c1 - Smoking Area Guidelines

14. 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

The facility was identified by the administrator as a smoke free campus, and that everyone must leave the grounds to smoke. At approximately 9:10 a.m. out the back exit to the building near room 524, there was an ashtray, a pack of cigarettes and a lighter.

Plan of Correction ***Accept (- 04/30/2026)***

Administrator, has informed all staff as of 3/31/2026 of the designated smoking area off campus. Policy Provided (See Attached) As of 3/31/2026 there will be no smoking out the back door near room 524. Monitoring will be conducted on this infraction and anyone found not following this policy will be dealt with through the disciplinary process.

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

Implemented (- 05/22/2026)

162c - Menus Posted

15. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 3/31/26 at 9:10 a.m. the home's menus were posted through the week ending 3/21/26.

162c - Menus Posted *(continued)*

Plan of Correction ***Accept (- 04/30/2026)***

Dietary staff was informed that the menu was not updated on 3/31/2026. A new menu was placed on 3/31/2026. (See Attached) Administrator, will audit menus weekly to be sure a new one has been placed starting 4/27/2026.

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

Implemented (- 05/22/2026)

183e - Storing Medications

16. 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

Resident #3 's lispro insulin pen and glargine insulin pen were not dated to indicate when the pens were opened. The manufacturer's instructions note the pens expire 28 days after opening.

Plan of Correction ***Accept (- 04/30/2026)***

Resident #3's insulin has been dated to indicate open date as of 3/31/2026. Staff on all three shifts were educated on the importance and requirement of dating the open date as of 3/31/2026. (See Education Log) Administrator, will audit weekly for three weeks then monthly for 3 months to ensure insulin is being dated properly. Findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations.

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

Implemented (- 07/23/2026)

184a - Resident's Meds Labeled

17. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #3 's lispro insulin pen and glargine insulin pen did not have pharmacy labels attached.

Resident #3 has an order for Metoprolol Succinate 50 mg tablets. The medication label notes administer 1 time daily in the morning. The resident's March 2026 medication administration record notes administer twice daily at 9:00 a.m. and 9:00 p.m. The medication record is correct.

Plan of Correction ***Accept (- 05/11/2026)***

A Medication Technician labeled the medication to match the eMAR and contacted the pharmacy to obtain an updated label. Staff across all shifts received education on 4/24/2026, regarding the importance of maintaining

184a - Resident's Meds Labeled (continued)

pharmacy labels on medications and ensuring that labels accurately match the eMAR (see attached education log). These actions will be monitored monthly for three months beginning 5/1/2026, and findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and any further recommendations.

Licensee's Proposed Overall Completion Date: *05/08/2026*

Implemented (- 07/23/2026)

185a - Implement Storage Procedures

18. 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 #3's glucometer was not calibrated to the correct time.

Plan of Correction ***Accept (- 05/11/2026)***

The Administrator, [redacted] updated Resident #3's glucometer to the correct time on 3/31/2026 (see attachment). The Administrator will conduct monthly audits for three months beginning 4/1/2026, to ensure all glucometers are calibrated to the correct time and date.

Licensee's Proposed Overall Completion Date: *05/08/2026*

Implemented (- 07/23/2026)

187d - Follow Prescriber's Orders

19. Requirements

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

Description of Violation

Resident #1 has an order for Eliquis Oral tablet, 2.5 mg, at 8:00 a.m. and 5:00 p.m. On 2/24/26, and 2/25/26, the medication was not administered. On 2/26/26 the medication was not administered at 8:00 a.m.

Resident # 5 has an order for Vitamin B-12 daily at 8:00 a.m. The medication was not administered on 2/1/26, 2/2/26, 2/3/26, and 2/4/26.

Repeat violation: 1/13/26

Plan of Correction ***Accept (- 04/30/2026)***

Administrator, [redacted] has educated staff on all shifts that medication must be administered as prescribed by the physician orders as of 4/1/2026. (Education Log Attached) Administrator, [redacted] will do audits monthly for 3 months to ensure meds are being administered properly and the findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations.

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

Implemented (- 05/22/2026)

190a - Completion Medication Course

20. Requirements

2600.
190.a. A staff person who has successfully completed a Department approved medications administration course that includes the passing of the Department's performance based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Person A passed the Department approved Medication Administration Course on 8/21/24. There has been no annual practicum completed since.

Staff Person B passed the Department approved Medication Administration Course on 4/26/24. There has been no annual practicum completed since.

Staff Person C passed the Department approved Medication Administration Course on 5/13/24. There has been no annual practicum completed since.

Repeat violation: 3/18/25

Plan of Correction ***Accept (- 05/11/2026)***

The Administrator, [redacted] contacted a Train-the-Trainer to ensure all staff are current with Medication Technician certifications. Staff Person A does not function as a Medication Technician and serves solely as a Direct Care Aide. Staff Persons B and C completed the Medication Administration Course on 4/10/2026 (see attachment). The Administrator will conduct monthly audits beginning 5/1/2026, to ensure all staff certifications remain up to date. Monitoring findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and any additional recommendations.

Licensee's Proposed Overall Completion Date: *05/08/2026*

Implemented (- 05/22/2026)

190b Insulin Injections

21. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department approved medications administration course that includes the passing of a written performance based competency test within the past 2 years, as well as successful completion of a Department approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person C's most recent diabetic training was completed on 4/25/24. On 3/19/26, 3/20/26, 3/25/26, 3/26/26, 3/27/26, and 3/30/26 at 5:00 p.m. Staff Person C administered Insulin Lispro to Resident #3.

Plan of Correction ***Accept (- 04/30/2026)***

As of 3/31/2026 all staff have been informed not to administer insulin unless their training is up to date. A diabetic training has been scheduled for 4/22/2026 to get all staff members who administer insulin up to date (See Attached). All staff will be diabetic certified by 5/1/2026. Administrator, [redacted] will audit monthly to ensure all staff certifications are up to date and the findings will be reported to the appropriate committees.

190b - Insulin Injections *(continued)*

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

Implemented (- 05/22/2026)

224a - Preadmission Screen Form

22. 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 #2 was admitted to the home on ; however, the resident's preadmission screening form was not completed.

Plan of Correction ***Accept (- 05/11/2026)***

The Administrator, did not complete a pre-admission screening prior to the admission of Resident #2, . A pre-admission screening had been completed at the time of admission Effective 4/1/2026, the Administrator implemented a checklist for all new admissions to ensure completion of all required documentation. Going forward, all admissions will have a pre-admission screening completed using the Department of Human Services pre-admission form prior to admission. The Administrator will conduct monthly audits for three months beginning 5/1/2026, to ensure all required documentation is completed for each resident.

Licensee's Proposed Overall Completion Date: *05/08/2026*

Implemented (- 05/22/2026)

225c - Additional Assessment

23. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Staff interviews and an interview with Resident #3 indicated that resident #3 needs assistance with toileting, bathing, dressing, and also that the resident ambulates with a walker. Resident 3's assessment, dated indicates the resident is independent with toileting, bathing, and dressing and does not note the resident uses a walker to aid with ambulation.

Repeat violation: 3/18/25

Plan of Correction ***Accept (- 04/30/2026)***

Resident #3's support plan has been updated to include the significant changes as of 4/21/2026 (See Attached). Administrator, will audit monthly to ensure all documents are up to date with changes for all residents starting 5/1/2026 and the findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations.

225c - Additional Assessment *(continued)*

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

Implemented (- 05/22/2026)

227g -Support Plan Signatures

24. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2 participated in the development of support plan on . However, the resident did not sign the support plan.

Resident #5 participated in the development of support plan on . However, the support plan was not signed by the resident or the assessor.

Plan of Correction ***Accept (- 04/30/2026)***

Resident #2 and Resident #5 have since signed their support plans as of 3/31/2026. (See Attached) Resident #5's support plan will be updated and signed by the Resident/responsible party and the assessor by 5/1/2026. Administrator, will audit monthly to ensure that all support plans are filled out to their entirety. Findings will be reported to the Quality Assurance and Performance Improvement committee for any further recommendations.

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

Implemented (- 07/23/2026)