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

August 18, 2026

[redacted]
ARHC WHWCHPA01 TRS LLC
[redacted]
EXECUTIVE DIRECTOR
[redacted]

RE: WELLINGTON COURT AT HERSHEY'S MILL
1361 EAST BOOT ROAD
WEST CHESTER, PA, 19380
LICENSE/COC#: 14136

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/13/2026, 04/14/2026 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**: *WELLINGTON COURT AT HERSHEY'S MILL* **License #**: *14136* **License Expiration**: *03/23/2027*

**Address**: *1361 EAST BOOT ROAD, WEST CHESTER, PA 19380*

**County**: *CHESTER* **Region**: *SOUTHEAST*

## Administrator

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

## Legal Entity

**Name**: *ARHC WHWCHPA01 TRS LLC*

**Address**: [redacted]

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

## Certificate(s) of Occupancy

**Type**: *I 1* **Date**: *01/31/1998* **Issued By**: *East Goshen Township*

**Type**: *I 2* **Date**: *01/31/1998* **Issued By**: *East Goshen Township*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *142* **Waking Staff**: *107*

## Inspection Information

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

**Reason**: *Complaint, Incident* **Exit Conference Date**: *04/14/2026*

## Inspection Dates and Department Representative

*04/13/2026 On Site* [redacted]

*04/14/2026 On Site* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *114* **Residents Served**: *96*

### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *Memory Care* **Capacity**: *40* **Residents Served**: *29*

### Hospice

**Current Residents**: *6*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *96*

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

**Have Mobility Need**: *46* **Have Physical Disability**: *0*

## Inspections / Reviews

### 04/13/2026 - Partial

**Lead Inspector**: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *05/21/2026*

## Inspections / Reviews *(continued)*

**05/28/2026 POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *06/26/2026*

**Reviewer:** [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/02/2026*

**06/10/2026 POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *06/26/2026*

**Reviewer:** [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/27/2026*

**08/18/2026 Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *06/26/2026*

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

## 42b - Abuse

### 1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

**Description of Violation**

*On [redacted] shortly after midnight, resident [redacted] eloped from the home's SDCU on the 1st floor via a delayed egress door to stair tower 2, which triggered the egress door alarm. Staff A and B, who were performing rounds on their assigned hallway, went to check the door. Both staff observed resident [redacted] walking away from the door and heading to [redacted] room. They assisted the resident back to bed and checked outside of the Exit, which was a stairwell with another exit to the outside and staircases leading down to the basement and up to the 2nd and 3rd floor. Since the staff persons did not observe a resident, they reset the alarm, assuming that resident [redacted] triggered the alarm. However, staff did not recognize that Resident [redacted] had eloped and proceeded to walk up four flights of stairs with about 40 steps. Around 01:00 AM, staff C was heading to a resident room near the 3rd floor stair tower 2 when [redacted] heard a knocking on the door. Staff C saw resident [redacted] standing outside in the stairwell through the door window and let the resident in. The resident appeared to be cold and scared, and not oriented to place. Resident [redacted] absence in the SDCU was not noticed until staff C brought the resident to the SDCU. Resident [redacted] utilizes a walker for ambulation; The resident did not have a walker with [redacted] when observed. The overnight low temperature was around 30 degrees Fahrenheit on [redacted]; The home's stairwells were not heated. Resident [redacted]s assessment and support plan describes the resident's supervision needs as "moderate" stating that [redacted] requires some supervision in the home and tends to wander, and that the resident has a "history of occasional disorientation to person, place, time, or situation even in familiar surroundings and requires supervision and oversight for safety." However, the plan is not specific in the frequency or specific interventions that direct care staff are to take.*

**Plan of Correction** ***Accept [redacted] - 05/28/2026)***

- *Upon notification by DHS, the Executive Director reviewed the circumstances surrounding the self-reported elopement incident and medication diversion.*
- *Resident rights and safety were protected, as the elopement incident resulted in no harm to the resident and the resident was safely redirected.*
- *Elopement training and policy was conducted for all Memory Care staff beginning on 02/17/2026 and completed on 02/23/2026. Training was completed by the Executive Director.*
- *An elopement drill was conducted on the overnight shift on 02/20/2026 by the Executive Director. Elopement drills are conducted monthly. The Executive Director or designee will continue indefinitely.*
- *Door chimes were installed in the memory care common areas on 02/23/2026 to provide additional alerts when egress is detected.*
- *Resident [redacted] had [redacted] care plan updated by Memory Care Director on 4/15/26 to reflect frequency and specific interventions for resident safety.*
- *The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on June 24, 2026.*

**Licensee's Proposed Overall Completion Date:** *05/19/2026*

***Implemented [redacted] - 08/18/2026)***

## 184a - Resident's Meds Labeled

**2. Requirements**

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

**Description of Violation**

*On [redacted], the pharmacy label for resident [redacted] read"1: (1) tablet by mouth once daily"; however, the order changed from once a day to twice a day on [redacted]*

**Plan of Correction** ***Accept [redacted] - 06/10/2026)***

*· Upon notification by DHS, resident [redacted] Vitamin C medication label was reviewed and corrected to reflect the current physician order of twice daily administration by the Health and Wellness Director on 4/14/26.*
*· Current Medication Technicians and Licensed Practical Nurses (LPNs) will be re-educated on medication labeling requirements under 55 Pa. Code § 2600.184(a), including the requirement that medication labels accurately reflect current physician orders and administration instructions.*
*· The Health and Wellness Director, or designee, will conduct the training.*
*· Training will begin on May 12, 2026 and will be completed no later than June 9, 2026.*
*· **The Health and Wellness Director or designee** will conduct audits to maintain compliance with regulation 2600.184(a).*
*· Beginning June 1, 2026, five resident medication records and corresponding Medication Administration Records (MARs) will be reviewed from each of the community's three medication carts every Monday, Wednesday, and Friday for four weeks following implementation of the Plan of Correction. This process will result in a total of 180 individual medication and MAR audits during the monitoring period with an end date of June 26th.*
*- Based on the community's current census of approximately 95 residents, this audit process will provide multiple review opportunities across the resident population and allow the community to evaluate the effectiveness of the audit.*
*- Audits will include verification that medications are available, physician orders match the MAR, medications are administered and documented correctly, required initials and signatures are present, special instructions are accurately transcribed and followed, medication counts are accurate, and all required documentation is complete.*
*· The results of the audit will be reviewed by the Executive Director or designee. Audit results will be maintained and available for DHS review*
*· The Executive Director will review audit outcomes with the Director team at the next scheduled Quality Assurance Meeting on June 24, 2026.*

**Licensee's Proposed Overall Completion Date:** *06/26/2026*

***Implemented [redacted] - 08/18/2026)***

## 185a Implement Storage Procedures

**3. 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**

*According to the home's Controlled Medication Management policy, controlled substances received are to be entered on a declining inventory sheet for controlled substances and each controlled substance should have its own declining inventory sheet. However, the declining inventory sheet for resident [redacted] 's [redacted] received on [redacted] could not be located at the home.*

*The policy also says that when a controlled substance is destroyed, two qualified staff [qualified staff includes licensed nurses and qualified medication administrators] will destroy the medication into appropriate receptacles and will sign off on the declining inventory sheet. On [redacted], resident [redacted] s [redacted] (total of 29) were signed as destroyed by staff B and staff D. Staff B is not qualified to administer medications. On [redacted] the home was notified that a package containing 2 full vials of morphine labeled as resident [redacted] prescription [redacted] syringes were found in a parking lot of a business center. The pharmacy that originally dispensed the medication confirmed that these vials matched the prescription number dispensed to the home that was signed off as being destroyed.*

**Plan of Correction** ***Directed ([redacted] - 06/10/2026)***

*• At time of incident, the Health and Wellness Director reviewed medication management practices related to the destruction of medications.*

*• It was identified that medications were destroyed without appropriate oversight. The employees involved were immediately suspended on 02/21/2026 and subsequently terminated. These employees did not return to the community.*

*• To prevent recurrence, the community has reinforced the requirement that medication destruction must be completed in accordance with established policy, including appropriate oversight and documentation.*

*• All Med Techs and LPNs will be re educated on the community's medication destruction policy and procedures. Training will be conducted by the Health and Wellness Director or designee.*

*• Training will begin 5/12/26 and will be completed no later than 6/9/26.*

*· Beginning June 1, 2026, five resident medication records and corresponding Medication Administration Records (MARs) will be reviewed from each of the community's three medication carts every Monday, Wednesday, and Friday for four weeks following implementation of the Plan of Correction. This process will result in a total of 180 individual medication and MAR audits during the monitoring period with an end date of June 26th.*

*Based on the community's current census of approximately 95 residents, this audit process will provide multiple review opportunities across the resident population and allow the community to evaluate the effectiveness of the audit.*

*Audits will include verification that medications are available, physician orders match the MAR, medications are administered and documented correctly, required initials and signatures are present, special instructions are accurately transcribed and followed, medication counts are accurate, and all required documentation is complete.*

*• The Health and Wellness Director or designee will conduct audits. Audit results will be maintained and available for DHS review*

*• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on June 24, 2026.*

*Proposed Overall Completion Date: 06/26/2026*

***Directed Plan of Correction (6/10/2026 -*** [redacted]

*Starting within 5 days of the receipt of the acceptable plan of correction, the administrator or designee qualified to*

## 185a - Implement Storage Procedures (continued)

*administer medications and of supervisory or management role, shall perform weekly observations of the destruction of narcotics for three months.*

**Directed Completion Date:** *06/26/2026*

***Implemented [redacted] - 08/18/2026)***

## 187a - Medication Record

**4. Requirements**

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

**Description of Violation**

*Resident [redacted]s April 2026 medication administration record (MAR) does not include a diagnosis or purpose for the following medications:*

- [redacted]
- [redacted]

**Plan of Correction** ***Accept [redacted] - 06/10/2026)***

*• Upon notification by DHS, the Health and Wellness Director reviewed medication administration practices related to labeling of medications for dosage.*
*• The identified medication(s) were immediately reviewed and labeling was clarified to ensure dosage instructions were clearly and accurately reflected by the Health and Wellness Director on 4/14/26.*
*• On 4/14/26 Health and Wellness Director conduced a review of current medication carts and medication records to ensure all medications are properly labeled with clear dosage instructions.*
*• To prevent recurrence, all Med-Techs and LPNs will be re-educated on proper medication labeling requirements, including ensuring dosage and diagnosis instructions are clearly documented and consistent with physician orders. Training will be conducted by the Health and Wellness Director or designee.*
*• Training will begin 5/12/26 and will be completed no later than 6/9/26.*
*• Beginning June 1, 2026, five resident medication records and corresponding Medication Administration Records (MARs) will be reviewed from each of the community's three medication carts every Monday, Wednesday, and Friday for four weeks following implementation of the Plan of Correction. This process will result in a total of 180 individual medication and MAR audits during the monitoring period with an end date of June 26th..*
*- Based on the community's current census of approximately 95 residents, this audit process will provide multiple*

## *187a Medication Record (continued)*

*review opportunities across the resident population and allow the community to evaluate the effectiveness of the audit.*

*Audits will include verification that medications are available, physician orders match the MAR, medications are administered and documented correctly, required initials and signatures are present, special instructions are accurately transcribed and followed, medication counts are accurate, and all required documentation is complete.*

*• The Health and Wellness Director or designee will conduct audits. Audit results will be maintained and available for DHS review*

*• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on June 24, 2026.*

**Licensee's Proposed Overall Completion Date:** *06/26/2026*

***Implemented [redacted] - 08/18/2026)***

## 187b - Date/Time of Medication Admin.

**5. Requirements**

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

**Description of Violation**

*Resident [redacted] was prescribed [redacted] every 4 hours as needed and [redacted] every 4 hours as needed. The declining inventory logs of these medications indicate that a dose of each medication was signed out on [redacted] at 6:24 PM; however, the resident's February MAR does not include the initials of the staff person who administered the [redacted] and [redacted] on [redacted] at 6:24 PM.*

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

**Plan of Correction** ***Accept [redacted] 06/10/2026)***

*· Upon notification by DHS, resident [redacted] February MAR and declining inventory documentation were reviewed to ensure medication administration documentation accurately reflected medications administered by the Health and Wellness Director.*

*· Current Medication Technicians and Licensed Practical Nurses (LPNs) will be re educated on medication administration documentation requirements under 55 Pa. Code § 2600.187(b), including the requirement that medications administered are documented on the MAR at the time of administration.*

*· The Health and Wellness Director, or designee, will conduct the training.*

*· Training will begin on May 12, 2026.*

*· All required training will be completed no later than June 9, 2026.*

*· The Health and Wellness Director or designee will conduct audits to maintain compliance with regulation 2600.187(b).*

*· Beginning June 1, 2026, five resident medication records and corresponding Medication Administration Records (MARs) will be reviewed from each of the community's three medication carts every Monday, Wednesday, and Friday for four weeks following implementation of the Plan of Correction. This process will result in a total of 180 individual medication and MAR audits during the monitoring period with an end date of June 26th.*

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

*- Based on the community's current census of approximately 95 residents, this audit process will provide multiple review opportunities across the resident population and allow the community to evaluate the effectiveness of the audit.*

*- Audits will include verification that medications are available, physician orders match the MAR, medications are administered and documented correctly, required initials and signatures are present, special instructions are accurately transcribed and followed, medication counts are accurate, and all required documentation is complete.*

*· The results of the audit will be reviewed by the Executive Director or designee. Audit results will be maintained and available for DHS review*

*· The Executive Director will review audit outcomes with the Director team at the next scheduled Quality Assurance Meeting on June 24, 2026.*

**Licensee's Proposed Overall Completion Date:** *06/26/2026*

***Implemented [redacted] - 08/18/2026)***

## 187d - Follow Prescriber's Orders

**6. Requirements**

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

**Description of Violation**

*Resident [redacted] 's [redacted] has a special instruction of 'DO NOT GIVE WITHIN 2 HRS OF MULTIVIT/CALCIUM' and the resident's April MAR scheduled this medication at 08:00 AM and 05:00 PM with a special instruction of 'ON AN EMPTY STOMACH 1 HOUR AWAY FROM CALLCIUM, VITAMINS, PROBIOTICS, and BOOST LIQUID'. However, the resident has been administered this medication along with other prescribed vitamins (such as B Complex Oral Capsule and [redacted], and [redacted] and probiotics [redacted] at 08:00 AM.*

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

**Plan of Correction** ***Accept [redacted] - 06/10/2026)***

*• Upon notification by DHS, the Health and Wellness Director reviewed medication administration practices related to following prescriber's orders.*

*• The identified medication order was immediately reviewed and clarified to ensure administration timing was consistent with the prescriber's instructions, including separation from other medications as ordered. Review was completed by the Health and Wellness Director on 4/14/26.*

*• The Medication Administration Record (MAR) was reviewed and updated as needed to reflect appropriate administration timing by the Health and Wellness Director on 4/14/26.*

*• To prevent recurrence, all Med-Techs and LPNs will be re-educated on following prescriber's orders, including proper timing of medication administration and adherence to specific instructions. Training will be conducted by the Health and Wellness Director or designee.*

*• Training will begin 5/12/26 and will be completed no later than 6/9/26.*

*· Beginning June 1, 2026, five resident medication records and corresponding Medication Administration Records (MARs) will be reviewed from each of the community's three medication carts every Monday, Wednesday, and Friday for four weeks following implementation of the Plan of Correction. This process will result in a total of 180 individual medication and MAR audits during the monitoring period with an end date of June 26th.*

*187d Follow Prescriber's Orders (continued)*

*Based on the community's current census of approximately 95 residents, this audit process will provide multiple review opportunities across the resident population and allow the community to evaluate the effectiveness of the audit.*

*Audits will include verification that medications are available, physician orders match the MAR, medications are administered and documented correctly, required initials and signatures are present, special instructions are accurately transcribed and followed, medication counts are accurate, and all required documentation is complete.*

*• Audits will be completed by the Health and Wellness Director or designee. Audit results will be maintained and available for DHS review*

*• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on June 24, 2026.*

**Licensee's Proposed Overall Completion Date:** *06/26/2026*

***Implemented [redacted] - 08/18/2026)***

**7. Requirements**

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

**Description of Violation**

*Resident [redacted] was prescribed [redacted] (1 tab by mouth twice a day at 07:00 AM and 04:00 PM); however, it was not administered to the resident because the medication was not available on [redacted] at 07:00 AM and 04:00 PM and [redacted] at 07:00 AM.*

**Plan of Correction** ***Accept [redacted] - 06/10/2026)***

*• Upon notification by DHS, the Health and Wellness Director reviewed the medication administration concern related to Resident [redacted] order.*

*• The identified medication order was reviewed to confirm the prescriber's directions for administration twice daily at 07:00 AM and 04:00 PM.*

*• The missed doses were reviewed by the Health and Wellness Director, and the resident's record/MAR was reviewed to ensure the medication was available and administered as ordered going forward. Review was completed by the Health and Wellness Director on 4/14/26.*

*• To prevent recurrence, all Med Techs and LPNs will be re educated on following prescriber's orders, timely medication administration, and the process for immediately reporting unavailable medications to the nurse and/or Health and Wellness Director. Training will be conducted by the Health and Wellness Director or designee.*

*• Training will begin 5/12/26 and will be completed no later than 6/9/26.*

*Beginning June 1, 2026, five resident medication records and corresponding Medication Administration Records (MARs) will be reviewed from each of the community's three medication carts every Monday, Wednesday, and Friday for four weeks following implementation of the Plan of Correction. This process will result in a total of 180 individual medication and MAR audits during the monitoring period with an end date of June 26th.*

*Based on the community's current census of approximately 95 residents, this audit process will provide multiple review opportunities across the resident population and allow the community to evaluate the effectiveness of the audit.*

*Audits will include verification that medications are available, physician orders match the MAR, medications are administered and documented correctly, required initials and signatures are present, special instructions are accurately transcribed and followed, medication counts are accurate, and all required documentation is complete.*

*• Audits will be completed by the Health and Wellness Director or designee. Audit results will be maintained and*

## 187d - Follow Prescriber's Orders (continued)

*available for DHS review.*

*• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on June 24, 2026.*

**Licensee's Proposed Overall Completion Date:** *06/26/2026*

***Implemented [redacted] - 08/18/2026)***

## 231c - Preadmission Screening

**8. Requirements**

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

**Description of Violation**

*Resident [redacted] was admitted to the Secured Dementia Care Unit (SDCU) on [redacted]. However, the resident's written cognitive preadmission screening was completed on [redacted]*

*Repeat Violation - [redacted]*

**Plan of Correction** ***Accept [redacted] - 06/10/2026)***

*• Upon notification by DHS, the Memory Care Director reviewed the cognitive preadmission screening documentation for residents admitted to the Secured Dementia Care Unit (SDCU).*
*• To prevent recurrence, the clinical leadership team including the Health and Wellness Director, Resident Care Coordinator, and the Memory Care Director have reviewed and reinforced the requirement that all residents admitted to the SDCU must have a completed cognitive preadmission screening within 72 hours prior to admission.*
*• A standardized admission checklist will be utilized to ensure all required documentation, including the cognitive preadmission screening form, is completed within the required timeframe prior to admission.*
*• The clinical leadership team will be re-educated on the requirements of 55 Pa. Code § 2600.231(c). Training will be conducted by the Executive Director or designee.*
*• Training will begin 5/12/26 and will be completed no later than 6/9/26.*
*• Ongoing compliance will be monitored through review of all SDCU admissions to ensure cognitive preadmission screenings are completed within the required timeframe.*
*• Audits will begin on June 1, 2026, and will be conducted every Monday, Wednesday, and Friday for four weeks. Audit results will be reviewed to identify trends, ensure compliance, and provide additional education as needed.*
*• During each audit, five resident records from the Secured Dementia Care Unit will be reviewed to verify that a completed cognitive preadmission screening is present and dated prior to admission. A total of 60 resident record audits will be completed during the four-week monitoring period. Based on the community's maximum Memory Care census of 30 residents, this audit process will provide multiple review opportunities across the resident population and support ongoing compliance with an end date of June 26th.*
*• Audits will be completed by the Health and Wellness Director or designee. Audit results will be maintained and available for DHS review.*
*• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on June 24, 2026.*

## 231c - Preadmission Screening (continued)

**Licensee's Proposed Overall Completion Date:** *06/26/2026*

***Implemented [redacted] - 08/18/2026)***

## 234b - Support Plan Needs Elements

**9. Requirements**

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

**Description of Violation**

*Resident [redacted] resided in the SDCU; however, the resident's RASP, dated [redacted], indicated that [redacted] had no supervision needs. However, the home developed a plan that states "[Resident] has current or history of occasional disorientation to person, place, time or situation even in familiar surroundings and requires supervision and oversight for safety reasons. [Resident] is a high fall risk and at times needs a lot of supervision on [redacted]*

**Plan of Correction** ***Accept [redacted] - 06/10/2026)***

*• Upon notification by DHS, the Health and Wellness Director reviewed the identified Resident Support Plans related to identification and documentation of resident needs.*
*• The identified Resident Support Plan were immediately reviewed and updated to accurately reflect this resident's physical, medical, cognitive, and safety needs, including appropriate supervision levels and interventions for identified conditions. Updates were completed by the Memory Care Director on 4/15/26.*
*• The clinical leadership team will be re-educated on the requirements of 55 Pa. Code § 2600.234(b), including ensuring support plans identify all resident needs and corresponding care strategies. Training will be conducted by the Executive Director or designee.*
*• Training will begin 5/12/26 and will be completed no later than 6/9/26.*
*• Ongoing compliance will be monitored through audits of Resident Support Plans in Memory Care to ensure all resident needs are accurately documented and appropriate interventions are in place.*
*• Audits will begin on June 1, 2026, and will be conducted every Monday, Wednesday, and Friday for four weeks. Audit results will be reviewed by the Memory Care Director or designee to identify trends, ensure compliance, and provide additional education as needed with an end date of June 26th.*
*• During each audit, five resident records from the Secured Dementia Care Unit will be reviewed to verify that supervision needs identified in assessments, evaluations, and other clinical documentation are accurately reflected in the resident's RASP. A total of 60 resident record audits will be completed during the four-week monitoring period. Based on the community's maximum Memory Care census of 30 residents, this audit process will provide multiple review opportunities across the resident population and support ongoing compliance.*
*• Audits will be completed by the Memory Care Director or designee. Audit results will be maintained and available for DHS review.*
*• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on June 24, 2026.*

**Licensee's Proposed Overall Completion Date:** *06/26/2026*

***Implemented [redacted] - 08/18/2026)***

## 251b - Record Entries Legible

**10. Requirements**

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

**Description of Violation**

*The 7th entry on resident [redacted] [redacted] (take 0.25 ml syringe by mouth every 2 hours as needed for pain/sob) declining inventory log (for the syringes received on [redacted]) was written over on The Quantity on Hand, The Time of Administration and The Quantity Remaining without proper notations.*

**Plan of Correction** ***Accept [redacted] - 05/28/2026)***

*• Upon notification by DHS, the Health and Wellness Director reviewed documentation practices related to medication records and narcotic count entries.*
*• The identified narcotic count record was reviewed by the Health and Wellness Director and staff were re-instructed to ensure all entries are legible, permanent, and not altered in a manner that obscures documentation.*
*• To prevent recurrence, all Med-Techs and LPNs will be re-educated on proper documentation requirements, including maintaining legible, permanent entries and appropriate correction procedures. Training will be conducted by the Health and Wellness Director or designee.*
*• Training will begin 5/12/26 and will be completed no later than 6/9/26.*
*• Ongoing compliance will be monitored through audits of medication records, including narcotic count sheets, to ensure entries are legible, complete, and properly documented.*
*• Audits will begin the week of May 18, 2026, and will be conducted weekly for four weeks, biweekly for four weeks, and monthly for one additional month, concluding the week of August 17, 2026, for a total monitoring period of three months.*
*• Audits will be completed by the Health and Wellness Director or designee. Audit results will be maintained and available for DHS review.*
*• The Executive Director will review outcomes with the Director team at the next scheduled Quality Assurance Meeting on June 24, 2026.*

**Licensee's Proposed Overall Completion Date:** *06/09/2026*

***Implemented [redacted] 08/18/2026)***