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

July 20, 2026

[redacted], REGIONAL
BROOKDALE SENIOR LIVING COMMUNITIES INC
[redacted]

RE: BROOKDALE NORTHAMPTON
65 RICHBORO-NEWTOWN ROAD
RICHBORO, PA, 18954
LICENSE/COC#: 12714

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/04/2026, 05/14/2026 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: *BROOKDALE NORTHAMPTON* **License #**: *12714* **License Expiration**: *07/16/2026*

Address: *65 RICHBORO NEWTOWN ROAD, RICHBORO, PA 18954*

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

Administrator

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

Legal Entity

Name: *BROOKDALE SENIOR LIVING COMMUNITIES INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *04/23/1993* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *101* **Waking Staff**: *76*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/14/2026*

Inspection Dates and Department Representative

05/04/2026 On Site: [redacted]

05/14/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SCDU* **Capacity**: *23* **Residents Served**: *17*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *72*

Diagnosed with Mental Illness: *4*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *29*

Have Physical Disability: *1*

Inspections / Reviews

05/04/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *06/18/2026*

Inspections / Reviews *(continued)*

06/24/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/17/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/29/2026*

06/30/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/17/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/17/2026*

07/20/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/17/2026*

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

54a - Direct Care Staff

2. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept ([redacted] - 06/24/2026)***

Direct Care Staff person B, is no longer employed with the community.
The Business Office Manager, or designee, will complete an audit of all employee files, by 6/30/2026, to ensure all Direct Care Staff persons have the required qualifications (HS diploma, GED or active registry status on the PA nurse aide registry) in their file.
The Business Office Manager, or designee, will audit the employee file of all newly hired Direct Care Staff persons on date of hire to ensure the required qualifications are included in their file.
The Executive Director will inservice the Business Office Manager on this violation, the regulation and plan to correct by 6/22/2026.
The Direct Care Staff Qualifications audit and inservice sign in sheets will be made available for review by the Department.
Direct care staff qualifications audit will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meetings, completed by 7/31/2026, and will be available for review by the Department.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 07/20/2026)

65g - Annual Training Content

3. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert during training year 1/1/2025 to 12/31/2025.

65g Annual Training Content (continued)

Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert during training year 1/1/2025 to 12/31/2025.

Repeat violation: 1/29/2025 et al

Plan of Correction ***Accept (- 06/30/2026)***

Staff person C is no longer employed with the community.
Staff person D attended the training via zoom on 11/19/2026. In person training will be completed with staff person D by 6/30/2026 for the 2025 training year. Inservice sign in sheet will be available for review by the Department.
An audit of all employee training records will be completed by the Executive Director to ensure all staff members received annual training conducted by a fire safety expert or by a staff person trained by a fire safety expert in person during the 2025 training year. Any staff member found not to have completed fire safety training for 2025 in person, will complete training in person no later than 7/31/2026. Audit and Inservice sign in sheet will be available for review by the Department.
In person training by a fire safety expert of by a staff person trained by a fire safety expert will be offered every quarter to ensure all staff receive for 2026 beginning 7/15/2026. Inservice sign in sheets will be available for review by the Department.
Fire Safety training will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meetings, by 7/31/2026, and will be available for review by the Department.

Licensee's Proposed Overall Completion Date: *07/15/2026*

Implemented (- 07/20/2026)

132d - Evacuation

4. 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

During the fire drill on 11/18/2025 at 6:32 pm. The home does have a maximum safe evacuation time of 15 minutes specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 15 minutes during the following drills; the home evacuated the residents within 18 minutes 19 seconds.

During the fire drill on 3/9/2026 at 6:07 am. The home does have a maximum safe evacuation time of 15 minutes specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 15 minutes during the following drills; the home evacuated the residents within 24 minutes 28 seconds.

132d - Evacuation (continued)

Plan of Correction ***Accept (- 06/24/2026)***

The community performed another fire drill during that same timeframe on another day within the same month. Successfully completed an evacuation to fire safe areas in 8m33s at 6:23p on11/24/2025; and successfully completed an evacuation to fire safe areas in 14m10s at 6:06a on 3/25/2026.
During debriefing of the unsuccessful fire drills on 11/18/25 and 3/9/2026, it was discussed that resident refusal to participate was the primary contributing factor.
The Executive Director reviewed the required evacuation time and requirement to participate in fire drills, per Home Rules listed in contract, with residents during Resident Council Meetings on 4/16/2026. & 5/21/2026.
The Executive Director will send a written notice, by 6/30/2026, to all residents and their responsible party reiterating the requirement of fire drill participation each month and that repeated failure to comply could result in a 30day notice to discharge.
The Basics for Fire Safety, including fire drills, was reviewed by Maintenance Manager during All Staff Meeting on 5/20/2026; and offered on the Relias learning platform.
The Executive Director will review the regulation, violation and plan to correct with department directors and staff by 7/15/2026.
Ongoing fire drills will be conducted each month per regulatory requirements and documented on the PA Fire Drill Log for Brookdale Northampton by the person conducting the fire drill. The PA Fire Drill Log for Brookdale Northampton and all follow up documentation to residents/responsible parties regarding compliance with participation will be available for review by the Department.
Fire Drills will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meeting, by 7/31/2026, and will be available for review by the Department.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented (- 07/20/2026)

132h - Designated Meeting Place

5. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 3/9/2026 at 6:07 am, All residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. Only 46 of the 68 residents evacuated to a fire safe area of the home.

During the fire drill on 11/18/2025 at 6:32 pm, All residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. Only 67 of the 72 residents evacuated to a fire safe area of the home.

Plan of Correction ***Accept (- 06/24/2026)***

Due to exceeding the community's required evacuation time of 15min, the community did not evacuate all residents in the home to a fire safe area.
The community performed another fire drill during that same timeframe on another day within the same month. Successfully completed an evacuation to fire safe areas in 8m33s at 6:23p on11/24/2025; and successfully

132h Designated Meeting Place (continued)

completed an evacuation to fire safe areas in 14m10s at 6:06a on 3/25/2026.
During debriefing of the unsuccessful fire drills on 11/18/25 and 3/9/2026, it was discussed that resident refusal to participate was the contributing factor.
The Executive Director reviewed the required evacuation time and requirement to participate in fire drills, per Home Rules listed in contract, with residents during Resident Council Meeting on 4/16/2026.
The Executive Director will send a written notice, by 6/30/2026, to all residents and their responsible party reiterating the requirement of fire drill participation each month and that repeated failure to comply could result in a 30day notice to discharge.
The Basics for Fire Safety, including fire drills, was reviewed by Maintenance Manager during All Staff Meeting on 5/20/2026; and offered on the Relias learning platform.
Ongoing fire drills will be conducted each month per regulatory requirements and documented on the PA Fire Drill Log for Brookdale Northampton by the person conducting the fire drill. The PA Fire Drill Log for Brookdale Northampton, all follow up documentation to residents regarding compliance with participation and Inservice sign in sheets will be available for review by the Department.
Fire Drills will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meeting, by 7/31/2026, and will be available for review by the Department.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 07/20/2026)

183d - Prescription Current

6. Requirements

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

Description of Violation

On 5/4/2026, Oxfloxacin .3% prescribed for Resident 1, was in the home's Medication cart; however, the medication was not a current medication on their medication administration record.

On 5/4/2026, Hydralazine HCL 25mg prescribed for Resident 1, was in the home's Medication cart; however, the medication was not a current medication on their medication administration record.

On 5/4/2026, Nystatin Powder prescribed for Resident 2, was in the home's Medication cart; however, the medication was not a current medication on their medication administration record.

On 5/4/2026, clotriazole Betameth 1 0.05% ream prescribed for Resident 3, was in the home's medication cart; however, the medication was discontinued on 4/7/2026.

Repeat Violation: 12/30/2025 et al

Plan of Correction ***Accept ([redacted] - 06/24/2026)***

The Oxfloxacin .3% and Hydralazine HCL 25mg for Resident 1; the Nystatin Powder for Resident 2; and the clotriazole Betameth 1 0.05% cream for Resident 3 were all removed from the home's medication cart at the time

183d - Prescription Current (continued)

of survey on 5/4/2026.
A Med Cart Audit was completed on each med cart by the Health & Wellness Coordinator on 5/12 & 5/13/2026.
The Health & Wellness Coordinator, or designee, will complete a med cart audit weekly, 6/1/2026 to 9/30/2026. The Health & Wellness Director or Executive Director will complete an additional med cart audit monthly 6/1/2026 to 9/30/2026.
The Executive Director will inservice the Health & Wellness Director and Health & Wellness Coordinators on this regulation, the violation and plan to correct by 6/30/2026.
The Health & Wellness Director will inservice all Med Techs on the regulation, the violation, plan to correct and the company's policy/procedure regarding Medication/Treatment Disposal by 7/15/2026.
Med cart Audits and Inservice sign in sheets will be made available for review by the Department.
Med Cart Audits will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meeting, by 7/31/2026, and will be available for review by the Department.

Licensee's Proposed Overall Completion Date: *07/15/2026*

Implemented ([redacted] - 07/20/2026)

183e - Storing Medications

7. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 5/4/2026, Resident 2's Tresiba Flex Pen was opened and not dated. According to the manufacturer's instructions this medication expires 56 days after opening.

On 5/4/2026 Latanoprost belonging to Resident 4, was opened with no open date. According to the manufacturer's instructions this medication expires after 6 weeks of opening.

On 5/4/2026 Latanoprost belonging to Resident 5, was opened with an open date of 3/6/2026. According to the manufacturer's instructions this medication expires after 6 weeks of opening.

On 5/4/2026, Acetaminophen 325 mg belonging to Resident 6. According to the manufacturer's label this medication expired on 4/30/2026.

Repeat violation: 1/29/2025 et al

Plan of Correction ***Accept ([redacted] - 06/24/2026)***

The Tresiba Flex Pen belonging to Resident 2 that was opened and not dated was removed and replaced; open date was inscribed as required.
The Latanoprost belonging to Resident 4 that was opened and not dated was removed and replaced; open date was inscribed as required.
The Latanoprost belonging to Resident 5 that was opened and not dated was removed and replaced; open date was inscribed as required.

183e Storing Medications (continued)

The Acetaminophen 325mg belonging to Resident 6 that expired on 4/30/2026 was removed and disposed of on the day of the survey (5/4/2026).
A medication cart audit was completed on each med cart by the Health & Wellness Coordinator on 5/12 & 5/13/2026.
Medication cart audits will be completed, to include checking for open dates and expiration dates on all prescribed medications, OTC medications and CAMs; any items found not to have open dates or to have expired will be removed and replaced. Med cart audits will be completed by the Health & Wellness Coordinator, or designee, weekly from 6/1 9/30/2026.
The Health & Wellness Director or Executive Director will complete an additional med cart audit monthly 6/1/2026 to 9/30/2026.
The Executive Director will inservice the Health & Wellness Director and Health & Wellness Coordinators on this regulation, the violation and plan to correct by 6/30/2026.
The Health & Wellness Director will inservice all Med Techs on the regulation, the violation, plan to correct and the company's policy/procedure regarding Medication/Treatment Disposal by 7/15/2026.
Med cart Audits and Inservice sign in sheets will be made available for review by the Department.
Med Cart Audits will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meeting, by 7/31/2026, and will be available for review by the Department.

Licensee's Proposed Overall Completion Date: *07/15/2026*

Implemented ([redacted] - 07/20/2026)

184a - Resident's Meds Labeled

8. 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

The pharmacy label for resident 7's Ativan 1 ml cream does not include the prescribed dosage and instructions for administration.

The pharmacy label for Resident 8's Magnesium Glycinate does not include the resident's name.

Plan of Correction ***Accept ([redacted] - 06/24/2026)***

Health & Wellness Coordinator followed up with Resident 7's physician. The Ativan 1ml cream was discontinued and a new order was received for the medication to be given in oral concentration form on 5/18/2026.
The resident's name was added to the pharmacy label for Resident 8's Magnesium Glycinate on 5/4/2026.
An initial med cart audit will be conducted by the Health & Wellness Director, or designee, by 6/30/2026. Audit will check all pharmacy labels to ensure they include the resident's name; the name of the medication; the date the prescription was issued; the prescribed dosage and instructions for administration; and the name and title of the prescriber. The pharmacy will be contacted for a new label for any medication found to be missing required

184a Resident's Meds Labeled (continued)

information on its label.
Upon receipt of any new medication, label will be checked to ensure all information is included and the pharmacy contacted for a new label if any of the required information is missing.
Medication cart audits will be completed, to include checking pharmacy labels for required information. Med cart audits will be completed by the Health & Wellness Coordinator or designee weekly from 6/1/2026 to 9/30/2026.
The Health & Wellness Director or Executive Director will complete an additional med cart audit monthly 6/1/2026 to 9/30/2026.
The Executive Director will inservice the Health & Wellness Director and Health & Wellness Coordinators on this regulation, the violation and plan to correct by 6/22/2026.
The Health & Wellness Director will inservice all Med Techs on the regulation, the violation, plan to correct by 7/15/2026.
Audits and Inservice sign in sheets will be made available for review by the Department.
Med Cart Audits will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meeting, by 7/31/2026, and will be available for review by the Department.

Licensee's Proposed Overall Completion Date: *07/15/2026*

Implemented ([redacted] - 07/20/2026)

184b - Labeling OTC/CAM

9. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 5/4/2026, a package of Magnesium Glycinate belonging to resident 8 was in the medication cart and was not labeled with the resident's name.

Repeat violation: 6/2/2025

Plan of Correction ***Accept ([redacted] - 06/24/2026)***

The resident's name was added to Resident 8's Magnesium Glycinate on 5/4/2026.
An initial med cart audit will be conducted by the Health & Wellness Director, or designee, by 6/30/2026. Audit to ensure any OTC medications and CAMs belonging to a resident includes the resident's name. The resident's name will be added to any OTC medication or CAM that does not include the resident's name.
Staff will check that any new OTC medication or CAM has the resident's name on it upon receipt and will add it if it is not included.
Medication cart audits will be completed, to include checking that any OTC medications and CAMs belonging to a resident include the resident's name.. Med cart audits will be completed by the Health & Wellness Coordinator or designee weekly from 6/1/2026 to 9/30/2026.
The Health & Wellness Director or Executive Director will complete an additional med cart audit monthly 6/1/2026 to 9/30/2026.
The Executive Director will inservice the Health & Wellness Director and Health & Wellness Coordinators on this regulation, the violation and plan to correct by 6/22/2026.
The Health & Wellness Director will inservice all Med Techs on the regulation, the violation, plan to correct by 7/15/2026.

184b - Labeling OTC/CAM (continued)

Audits and Inservice sign in sheets will be made available for review by the Department.
Med Cart Audits will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meeting, by 7/31/2026, and will be available for review by the Department.

Licensee's Proposed Overall Completion Date: *07/15/2026*

Implemented ([redacted] - 07/20/2026)

185a - Implement Storage Procedures

10. 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

On 5/4/2026 at 7:54 am, Resident 3's glucometer reading was 105 and was documented on the medication administration record as 103.

On 5/4/2026 at 12:12 pm, the glucometer belonging to Resident 3 was not calibrated correctly. The time shown on the glucometer was 5/4/2026 12:22 pm.

Resident 7 is prescribed Hyoscyamine Sulfate as needed. On 5/4/2026 this medication(s) was not available in the home.

Plan of Correction ***Accept ([redacted] - 06/24/2026)***

The MAR for Resident 3's glucometer reading on 5/4/2026 at 7:54am was corrected from 103 to 105 reflect the reading on the glucometer by the Health & Wellness Coordinator on 6/9/2026.
The glucometer for Resident 3 was recalibrated at that time.
The Hyoscyamine Sulfate prescribed as needed for Resident 7 was received from pharmacy on 5/5/2026 and placed in the medication cart.
An audit of all glucometer readings vs documentation on MAR for the month of June will be completed by the Health & Wellness Coordinator, or designee, by 6/30/2026.
All glucometers will be recalibrated at completion of audit and according to the manufacturers recommendation thereafter.
An audit of glucometer readings vs documentation on MAR audits will be completed the Health & Wellness Coordinator or designee monthly from 6/1/2026 to 9/30/2026. Audits will be reviewed and verified as complete by the Health & Wellness Director or Executive Director monthly from 6/1/2026 to 9/30/2026.
Medication cart audits will be completed, to include all prescribed meds are on the med cart. Med cart audits will be completed by the Health & Wellness Coordinator or designee weekly from 6/1-9/30/2026.
The Health & Wellness Director or Executive Director will complete an additional med cart audit monthly 6/1/2026 to 9/30/2026.
A medication delivery/medication missed report will be run 2x/week and will be reviewed by the Health &

185a - Implement Storage Procedures (continued)

Wellness Coordinator, or designee, to determine if any new or refilled medications have not been received. Health & Wellness Coordinator, or designee, will follow up with pharmacy, via email, to ensure medication is delivered.
The Executive Director will inservice the Health & Wellness Director and Health & Wellness Coordinators on this regulation, the violation and plan to correct by 6/22/2026.
The Health & Wellness Director will inservice all Med Techs on the regulation, the violation, plan to correct by 7/15/2026.
Audits and Inservice sign in sheets will be made available for review by the Department.
Med Cart Audits and Glucometer/MAR Audits will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meeting, by 7/31/2026, and will be available for review by the Department.

Licensee's Proposed Overall Completion Date: *07/15/2026*

Implemented ([redacted] - 07/20/2026)

187b - Date/Time of Medication Admin.

11. 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 2 is prescribed Oxycodone 5mg. Resident 2's Oxycodone 5mg medication administration record does not include the initials of the staff person who administered Oxycodone 5mg on 4/14/2025 at 8:55 pm.

Resident 2 is prescribed Oxycodone 5mg. Resident 2's Oxycodone 5mg medication administration record does not include the initials of the staff person who administered Oxycodone 5mg on 4/16/2025 at 9:33 pm.

Resident 9 is prescribed Hydrocodon 7.5 mg, On 5/4/2026 the morning dose, Medication Administration record shows as being administered. However, the medication was not given to the resident because it was refused.

Plan of Correction ***Accept ([redacted] - 06/24/2026)***

The Health & Wellness Coordinator identified the MedTech who administered the medications on 4/14/2026 at 8:55pm and 4/16/2026 at 9:33pm and verified Resident 2 did receive the Oxycodone 5mg as prescribed. A late entry note was added to Resident 2's record on 5/6/2026.
A late entry notation was added to Resident 9's record to reflect that the morning dose of Hydrocodon 7.5mg was not given to the resident because it was refused on 5/6/2026.
The Health & Wellness Director will complete 2 med pass observations on the MedTechs involved to ensure proper procedures are being followed by 7/15/2026. Observations will be documented on each of their observation forms and will be available for review by the Department.
The Health & Wellness Director, or designee, will check the PCC Portal daily to determine if there are any medications that were not signed out over the past 24hours from 7/1/2026 to 9/30/2026. The HWD, or designee, will contact the MedTech to verify the medication was given and to have that MedTech sign out the medication as given; a notation will be made in the record that the med was given, but not signed out at the time it was administered. If it is not verified that the medication was given, then the proper steps will be taken for reporting.
The Health & Wellness Director will inservice all MedTechs on the proper procedures for passing medications, including documenting the medication was given after the resident takes them and ensuring narcotics are signed

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

out on the eMAR as well as the narcotic sheet. Inservice will be completed by 7/15/2026.
The Executive Director will inservice the Health & Wellness Director and Health & Wellness Coordinators on this regulation, the violation and plan to correct by 6/22/2026.
Audits and all Inservice sign in sheets will be made available for review by the Department.

Licensee's Proposed Overall Completion Date: *07/15/2026*

Implemented ([redacted] - 07/20/2026)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident 2 is prescribed Ferrous Sulfate. However, this medication was not administered to resident 2 since 4/23/2026 because the medication was not available in the home.

Resident 7 is prescribed Midodrine 5 mg. This medication has special instructions to hold is blood pressure is above 130. On 5/1/2026 the home did not check Resident 7's blood pressure at 9:00 am and 5:00 pm.

Resident 7 is prescribed Metropolol ER 50 mg twice a day. This medication has special instructions to hold if heart rate is less than 60 On 5/1/2026, the home did not measure Resident 7's heart rate at 9:00am and 9:00 pm.

Resident 7 is prescribed Metropolol ER 50 mg twice a day. This medication has special instructions to hold if heart rate is less than 60 On 5/3/2026, the home did not measure Resident 7's heart rate at 9:00am. The vitals were out of parameters, and they did not administer the medication.

Repeat violation: 6/2/2025

Plan of Correction ***Accept ([redacted] - 06/24/2026)***

The Health & Wellness Coordinator contacted the prescribing physician for Resident 2; no follow up instructions were provided by the prescriber regarding the missed Ferrous Sulfate, other than to begin the order upon receipt of medication.
The Health & Wellness Coordinator completed a review of the prescribing physician orders for Midodrine and Metoprolol ER for Resident 7 on the day of survey 5/4/2026. The physician was notified of the missed assessments and no follow up instructions were given other than to monitor for any adverse outcomes; none noted.
An audit of the medication administration record (MAR) for all residents will be completed by the Health & Wellness Director, or designee, to identify any medications not available in the community, medications requiring parameters and/or documentation gaps related to prescriber instructions. Audit will be completed by 7/15/2026. Any discrepancies identified will be addressed by notifying the physician and/or coordinating delivery of medications with pharmacy.
The Health & Wellness Director, or designee, will complete a weekly audit of medication administration records from 7/20/2026 to 9/30/2026. Audits will be made available for review by the Department.
The Health & Wellness Director will inservice all MedTechs on the proper procedures for completing assessments for medications requiring clinical parameters, such as blood pressure or heart rate, before administering the

187d - Follow Prescriber's Orders (continued)

medication. Inservice will be completed by 7/15/2026.
The Executive Director will inservice the Health & Wellness Director and Health & Wellness Coordinators on this regulation, the violation and plan to correct by 6/22/2026.
Audits and all Inservice sign in sheets will be made available for review by the Department.

Licensee's Proposed Overall Completion Date: *07/15/2026*

Implemented (- 07/20/2026)

227g -Support Plan Signatures

13. 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 10 participated in the development of support plan on . However, the resident did not sign the support plan.

Repeat violation: 12/30/2025 et al, 6/2/2025

Plan of Correction ***Accept (- 06/24/2026)***

An attempt was made to obtain a signature from Resident 10; however, due to level of dementia, was unable to sign. A notation was made on the support plan.
An audit of all current resident records to ensure the support plan has a date and signature from individuals who participated by the Health & Wellness Director, or designee, by 6/30/2026. If a resident is unable to sign, a notation will be made and dated.
The Executive Director, or designee, will audit annual support plans or support plans completed due to a significant change 1x/month from 6/1/2026 to 9/30/2026 to ensure the support plans have a date and signature from individuals who participated or a notation is made if a resident was unable to sign.
The Executive Director will inservice the Health & Wellness Director and Health & Wellness Coordinators on this regulation, the violation and plan to correct by 6/22/2026.
Audits and Inservice sign in sheets will be made available for review by the Department.
The Support Plan Signature Audit will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meeting, by 7/31/2026, and will be available for review by the Department.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented (- 07/20/2026)

231c - Preadmission Screening

14. 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 10 was admitted to the Secure Dementia Care Unit (SDCU) on . However, the resident 10

231c - Preadmission Screening (continued)

's written cognitive preadmission screening was not completed.

Resident 11 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident 11's written cognitive preadmission screening was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 06/24/2026)***

A written cognitive preadmission screening for Resident 10 was completed on 5/6/2026.
An audit on resident records to ensure all residents in the Secured Dementia Care Unit have a completed cognitive preadmission screening will be completed by the Health & Wellness Director, or designee, by 6/30/2026.
An audit will be completed by the Executive Director, or designee, on any newly admitted resident, within the first day move-in, to ensure a written cognitive preadmission screening is completed within 72 hours prior to admission.
The Executive Director will inservice the Health & Wellness Director and Health & Wellness Coordinators on this regulation, the violation and plan to correct by 6/22/2026.
Audits and Inservice sign in sheets will be made available for review by the Department.
The Cognitive Preadmission Screening Audit will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meeting, by 7/31/2026, and will be available for review by the Department.

Licensee's Proposed Overall Completion Date: *06/30/2026*

Implemented ([redacted] - 07/20/2026)

236 - Staff Training

15. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person C, who works in the Secure Dementia Care Unit (SDCU) had only 3.75 hours of training in dementia care during the 1/1/2025 to 12/31/2025 training year.

Plan of Correction ***Accept ([redacted] - 06/30/2026)***

Direct care staff person C is no longer employed by the community.

An audit of the 2025 training records for direct care staff persons working in the secured dementia care unit will be completed by the Business Office Manager, or designee, to ensure 6 hours of annual training related to dementia care and service is completed by 6/30/2026. Any direct care staff person working in the secured dementia unit who does not have the required 6 hours of training will complete training for the 2025 calendar year by 7/31/2026.
The Business Office Manager, or designee, will conduct an audit of direct care staff persons working in the secured care unit in October, November and December 2026 to ensure the required 6 hours of annual training related to dementia care and services is completed for the 2026 calendar year.
The Executive Director will inservice Business Office Manager on this regulation, the violation and plan to correct by 6/22/2026.
Audits and Inservice sign in sheets will be made available for review by the Department.
The Staff Training Audit will be reviewed by the Executive Director with current department directors during the quarterly Quality Assurance Review meeting, by 7/31/2026, and will be available for review by

236 - Staff Training (continued)

Licensee's Proposed Overall Completion Date: *07/15/2026*

Implemented ([redacted] - 07/20/2026)