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

July 17, 2026

[redacted], ADMINISTRATOR
HIDDEN MEADOWS OPCO LLC
[redacted]

RE: HIDDEN MEADOWS ON THE RIDGE
THE LAURELS
340 FARMERS LANE
SELLERSVILLE, PA, 18960
LICENSE/COC#: 14524

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/04/2026 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: *HIDDEN MEADOWS ON THE RIDGE THE LAURELS* **License #**: *14524* **License Expiration**: *07/20/2026*

Address: *340 FARMERS LANE, SELLERSVILLE, PA 18960*

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

Administrator

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

Legal Entity

Name: *HIDDEN MEADOWS OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/05/2014* **Issued By**: *West Rockhill Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *76* **Waking Staff**: *57*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/04/2026*

Inspection Dates and Department Representative

05/04/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *38*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Whole Home* **Capacity**: *50* **Residents Served**: *38*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *38*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *38*

Have Physical Disability: *1*

Inspections / Reviews

05/04/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/25/2026*

05/26/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/11/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/31/2026*

Inspections / Reviews *(continued)*

06/01/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/11/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/14/2026*

07/17/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/11/2026*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

In January 2026, specific date and time unknown, Resident 1 called Staff Person A a bitch. In response to this, Staff Person A "popped" Resident 1 in the mouth with the back of [redacted] hand. This incident was observed by Staff Person B. This incident was reported to Staff Persons C and D on 2/12/2026 at 4:30 PM. This allegation of abuse, which occurred in January, was not reported to the local area agency on aging until 2/12/2026.

Plan of Correction ***Accept ([redacted] - 05/26/2026)***

- On 2/12/26, as soon as the Executive Director (ED) and Director of Health and Wellness (DHW) became aware of the incident from January 2026, an oral report was immediately made to the local Area Agency on Aging.
- On 2/12/26, as soon as the ED and DHW became aware of the incident, Staff Person B who didn't report the incident from January 2026 until 2/12/26 was retrained on the requirements of regulation 15a.
- On 2/12/26, Divisional Director of Resident Care retrained ED and Memory Care Director (MCD) on the requirements of regulation 2600.15a.
- Starting 2/20/26, the ED, DHW and/or MCD began retraining the staff on the requirements of regulation 2600.15a.
- In March 2026, the ED started conducting monthly staff trainings on the Older Adult Protective Services Act (OAPSA) and mandatory abuse reporting. This monthly training by the ED or designee will continue through October 2026.
- On 3/16/26, the DHW, MCD, and/or designee started conducting 2 resident and 2 staff interviews regarding abuse weekly. The 2 resident and 2 staff interviews regarding abuse will continue weekly through October 2026 to ensure ongoing compliance with regulation 2600.15a.
-Documentation of training sessions will be maintained to ensure compliance

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 07/17/2026)

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

In January 2026, specific date and time unknown, Resident 1 called Staff Person A a bitch. In response to this, Staff Person A "popped" Resident 1 in the mouth with the back of [redacted] hand. The home did not develop and implement a plan of supervision or suspend Staff Person A until 2/12/2026.

Plan of Correction ***Accept ([redacted] - 05/26/2026)***

- On 2/12/26, as soon as the ED and DHW became aware of the incident, Staff Person A was interviewed then immediately suspended pending an investigation. Staff Person A was subsequently terminated on [redacted]
- On 2/12/26, as soon as the ED and DHW became aware of the incident, Staff Person B who didn't report the

15b Supervisor Plan (continued)

incident from January 2026 until 2/12/26 was retrained on the requirements of regulation 15b.

On 2/12/26, Divisional Director of Resident Care retrained ED and MCD on the requirements of regulation 2600.15b.

Documentation of training sessions will be maintained to ensure compliance.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 07/17/2026)

16c - Written Incident Report

3. 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

In January 2026, specific date and time unknown, Resident 1 called Staff Person A a bitch. In response to this, Staff Person A "popped" Resident 1 in the mouth with the back of hand. This incident, which occurred in January 2026, was not reported to the department until 2/12/2026 at 6:15 PM.

Repeat Violation: 6/4/2025

Plan of Correction ***Accept (- 05/26/2026)***

On 2/12/26, as soon as the ED and DHW became aware of the incident, the incident was reported via email to the Department's personal care home regional office.

On 2/12/26, as soon as the ED and DHW became aware of the incident, Staff Person B who didn't report the incident from January 2026 until 2/12/26 was retrained on the requirements of regulation 16c and provided with a counseling.

On 2/12/26, Divisional Director of Resident Care retrained ED and MCD on the requirements of regulation 2600.16c.

Starting 2/20/26, the ED, DHW and/or Memory Care Director (MCD) began retraining the staff on the requirements of regulation 2600.16c.

Starting 5/18/26, all incidents will be reviewed during the morning department director meeting three times weekly for 6 weeks then twice weekly for 6 weeks then weekly for 6 weeks to ensure compliance with regulation 2600.16c.

Documentation of training sessions will be maintained to ensure compliance.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 07/17/2026)

42b - Abuse

4. 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

In January 2026, specific date and time unknown, Resident 1 called Staff Person A a bitch. In response to this, Staff Person A "popped" Resident 1 in the mouth with the back of hand.

42b Abuse (continued)

Repeat Violation: 6/4/2025, 4/16/2025

Plan of Correction ***Accept (- 05/26/2026)***

On 2/12/26, as soon as the ED and DHW became aware of the incident, resident 1 was assessed. Resident 1 had no pain/discomfort or signs of injury and no recollection of the incident. Resident 1's responsible party and primary care physician were notified of the incident. No new orders were received.

On 2/12/26, as soon as the ED and DHW became aware of the incident, Staff Person A was interviewed then immediately suspended pending an investigation. Staff Person A was subsequently terminated on

On 2/12/26, as soon as the ED and DHW became aware of the incident, Staff Person B who didn't report the incident from January 2026 until 2/12/26 was retrained on the requirements of regulation 2600.42b.

On 2/12/26, Divisional Director of Resident Care retrained ED and MCD on the requirements of regulation 2600.42b.

Starting 2/20/26, the ED, DHW and/or MCD began retraining the staff on the requirements of regulation 2600.42b.

In March 2026, the ED started conducting monthly staff trainings on the Older Adult Protective Services Act (OAPSA) and mandatory abuse reporting. This monthly training by the ED or designee will continue through October 2026.

On 3/16/26, the DHW, MCD, and/or designee started conducting 2 resident and 2 staff interviews regarding abuse weekly. The 2 resident and 2 staff interviews regarding abuse will continue weekly through October 2026 to ensure ongoing compliance with regulation 2600.42b.

Documentation of training, meetings, and communication will be maintained.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 07/17/2026)

65a - FS Orientation 1st Day

5. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Person C, whose first day of work was did not receive orientation on the following topics: staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, the location and use of fire extinguishers, and/or smoke detectors and fire alarms until 3/18/2026.

65a - FS Orientation 1st Day (continued)

Repeat Violation: 4/16/2025

Plan of Correction ***Accept (- 06/01/2026)***

- Staff person C was trained on 2/2/2026 by a Fire Safety Expert on staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, the location and use of fire extinguishers, and/or smoke detectors and fire alarms but this training was not documented until 3/18/2026. The Fire Safety Expert who trained Staff person C is no longer employed by the community as of [redacted] so no retraining could be provided to [redacted]
- On 5/4/2026, the Division Director of Resident Care provided retraining to the Executive Director on the requirements of Regulation 2600.65.a.
- On 5/5/2026, the Memory Care Director conducted a retraining for the community leadership team on the requirements of regulation 2600.65.a.
- On 5/20/2026, the Executive Director conducted a retraining for the new Director of Culinary on the requirements of regulation 2600.65.a.
- By 6/12/26, BOD or designee will audit current employees files to verify compliance with regulation 2600.65a.
- Starting the week of 6/1/2026, the BOD or designee will audit 3 staff files twice weekly for 4 weeks then weekly for 4 weeks then biweekly for 2 months to ensure ongoing compliance with regulation 2600.65a.
- Documentation of training and meetings will be maintained.

Licensee's Proposed Overall Completion Date: *06/12/2026*

Implemented (- 07/17/2026)

65b - Rights/Abuse 40 Hours

6. 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:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Person C completed [redacted] 40th scheduled work hour on [redacted] However, this Staff Person did not complete training in the following topics: emergency medical plan, and/or reporting of reportable incidents and conditions until 3/18/2026.

Repeat Violation: 4/16/2025

Plan of Correction ***Accept (- 06/01/2026)***

- Staff person C was trained on 2/2/2026 on the emergency medical plan, and reporting of reportable incidents and conditions but this training was not documented until 3/18/2026. The staff member who trained Staff person C is no longer employed by the community as of [redacted], so no retraining could be provided to [redacted]
- On 5/4/2026, the Division Director of Resident Care provided retraining to the Executive Director on the requirements of Regulation 2600.65.b.

65b - Rights/Abuse 40 Hours (continued)

- On 5/5/2026, the Memory Care Director conducted a retraining for the community leadership on the requirements of regulation 2600.65.b.
- On 5/20/2026, the Executive Director conducted a retraining for the new Director of Culinary on the requirements of regulation 2600.65.b.
- By 6/12/26, BOD or designee will audit current employees files to verify compliance with regulation 2600.65b.
- Starting the week of 6/1/2026, the BOD or designee will audit 3 staff files twice weekly for 4 weeks then weekly for 4 weeks then biweekly for 2 months to ensure ongoing compliance with regulation 2600.65b.
- Documentation of training and meetings will be maintained.

Licensee's Proposed Overall Completion Date: *06/12/2026*

Implemented (- 07/17/2026)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct Care Staff Person A did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 1/1/2025 through 12/31/2025.

Direct Care Staff Person E did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 1/1/2025 through 12/31/2025.

Plan of Correction ***Accept (- 06/01/2026)***

- Staff person A was terminated on
- On 2/11/2026, staff person E was trained on the requirements of regulation 2600.65.f.
- On 2/10/2026, the Division Director of Resident Care provided retraining to the Executive Director and other members of the community leadership following a state visit during which this violation was noted.
- On 2/11/2026, the Executive Director conducted a retraining for the community leadership team on the requirements of regulation 2600.65.f.
- On 2/25/2026, during a staff meeting, the Executive Director retrained the community team on the requirements of regulation 2600.65.f.
- On 4/29/2026, during a staff meeting, the Director of Health and Wellness retrained the community team on the requirements of regulation 2600.65.f.
- On 5/4/2026, the Division Director of Resident Care provided retraining to the Executive Director on the

65f - Training Topics (continued)

requirements of Regulation 2600.65.f.

- On 5/5/2026, the Memory Care Director conducted a retraining for the community leadership on the requirements of regulation 2600.65.f.

- On 5/20/2026, the Executive Director conducted an additional training session for the community leadership team on the requirements of regulation 2600.65.f.

- By 6/12/26, BOD or designee will audit current employees files to verify compliance with regulation 2600.65f.

- Starting the week of 6/1/2026, the BOD or designee will audit 3 staff files twice weekly for 4 weeks then weekly for 4 weeks then biweekly for 2 months to ensure ongoing compliance with regulation 2600.65f.

- Documentation of training and meetings will be maintained.

Licensee's Proposed Overall Completion Date: *06/12/2026*

Implemented ([redacted] - 07/17/2026)

65g - Annual Training Content

8. 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 A 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, emergency preparedness procedures and recognition and response to crises and emergency situations, and/or the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), during training year 1/1/2025 through 12/31/2025.

Staff Person E 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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, and/or the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), during training year 1/1/2025 through 12/31/2025.

Staff Person F 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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, and/or new population groups that are being served at the home that were not previously served, if applicable, during training year 1/1/2025 through 12/31/2025.

65g Annual Training Content *(continued)*

Plan of Correction ***Accept (- 06/01/2026)***

Staff person A was terminated on

On 3/25/2026, staff person E was trained on the requirements of regulation 2600.65.g.

Staff person F last worked on and the community is in process of termination for failure to complete required trainings.

On 2/10/2026, the Division Director of Resident Care provided retraining to the Executive Director and other members of the community leadership following a state visit during which violation 2600. 65.g was noted.

On 2/11/2026, the Executive Director conducted a retraining for the community leadership team on the requirements of regulation 2600.65.g.

On 2/25/2026, during a staff meeting, the Executive Director retrained the community team on the requirements of regulation 2600.65.g.

On 4/29/2026, during a staff meeting, a staff trained by a Fire Safety Expert retrained the community team on the requirements of regulation 2600.65.g.

On 5/4/2026, the Division Director of Resident Care provided retraining to the Executive Director on the requirements of Regulation 2600.65.g.

On 5/5/2026, the Memory Care Director conducted a retraining for the community leadership on the requirements of regulation 2600.65.g.

On 5/20/2026, the Executive Director conducted an additional training session for the community leadership team on the requirements of regulation 2600.65.g.

By 6/12/26, BOD or designee will audit current employees files to verify compliance with regulation 2600.65g.

Starting the week of 6/1/2026, the BOD or designee will audit 3 staff files twice weekly for 4 weeks then weekly for 4 weeks then biweekly for 2 months to ensure ongoing compliance with regulation 2600.65g.

Documentation of training and meetings will be maintained.

Licensee's Proposed Overall Completion Date: *06/12/2026*

Implemented (- 07/17/2026)

85d - Trash Receptacles

9. Requirements

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

Description of Violation

On 5/4/2026 there were three uncovered, unattended trash cans in the Main Kitchen.

Plan of Correction ***Accept (- 05/26/2026)***

On 5/5/2026, an order was placed for the three missing trash can lids in the main kitchen. The three trash can lids arrived on 5/8/2026 and were immediately placed on the three trash cans in the main kitchen to ensure compliance with regulation 2600.85.d.

On 5/4/2026, the Division Director of Resident Care provided retraining to the Executive Director on the requirements of Regulation 2600.85.d.

On 5/4/2026, the Executive Director began conducting training for the staff in the Culinary Department on the requirements of Regulation 2600.85.d.

On 5/20/2026, the Executive Director conducted a training session with the new Director of Culinary on the requirements of Regulation 2600.85.d.

85d - Trash Receptacles (continued)

- Starting the week of 5/25/2026, the Director of Culinary or designee will audit the kitchen to ensure all trash cans are covered three times weekly for 4 weeks, then twice weekly for 4 weeks then weekly for 4 weeks to ensure compliance with Regulation 2600.85.d.

- Documentation of training and meetings will be maintained.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 07/17/2026)

101o - Walls, Floors, Ceilings

10. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The ceiling in bedroom A-1 is water stained and has a paint chip approximately 6 inches long hanging from it.

Plan of Correction ***Accept (- 05/26/2026)***

- On 5/4/2026, the Division Director of Resident Care provided retraining to the Executive Director on the requirements of Regulation 2600.101.o.

- On 5/5/2026, the Memory Care Director conducted a retraining for the community leadership on the requirements of regulation 2600.101.o.

- On 5/21/26, the ceiling was temporarily repaired to ensure compliance with Regulation 2600.101.o.

- On 5/25/26, a contractor is scheduled to come to the community to repair the roof and permanently repair the ceiling in apartment A1.

- Starting the week of 5/18/2026, the Memory Care Director or designee will check 10 rooms weekly for the next 6 weeks, then biweekly for the next 6 weeks, and finally monthly for 3 months to ensure compliance with Regulation 2600.101.o.

- Documentation of training and meetings will be maintained.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented (- 07/17/2026)

103c - Food Protected

11. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 5/4/2026, during lunch service, Staff Person G was not wearing a hair net.

Plan of Correction ***Accept (- 05/26/2026)***

- On 5/4/2026, staff member G put on a hairnet immediately after the state brought it to attention during the inspection to ensure compliance with regulation 2600.103.c.

- On 5/4/2026, the Division Director of Resident Care provided retraining to the Executive Director on the requirements of Regulation 2600.103c.

- On 5/4/2026, the Executive Director trained Staff Person G on the requirements of Regulation 2600.103c.

- On 5/20/2026, the Executive Director conducted a training session with the new Director of Culinary on the requirements of Regulation 2600.103.c.

103c Food Protected (continued)

Starting the week of 5/25/2026, the Director of Culinary or designee will check to ensure staff who are storing, preparing, transporting or serving food are wearing hair nets at one meal per day, three times weekly for 4 weeks, then one meal per day, twice weekly for 4 weeks then one meal per day, weekly for 4 weeks to ensure compliance with Regulation 2600.103c.

Documentation of training and meetings will be maintained.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 07/17/2026)

103e - Left Overs

12. Requirements

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

Description of Violation

On 5/4/2026, there were two unlabeled, undated bags of pasta in dry goods storage.

Repeat Violation: 5/1/2025

Plan of Correction ***Accept ([redacted] - 05/26/2026)***

On 5/4/2026, during the inspection, the two unlabeled, undated bags of pasta were immediately discarded to ensure compliance with regulation 2600.103.e.

On 5/4/2026, the Division Director of Resident Care provided retraining to the Executive Director on the requirements of Regulation 2600.103.e.

On 5/4/2026, the Executive Director began conducting training for the staff in the Culinary Department on the requirements of Regulation 2600.103.e.

On 5/20/2026, the Executive Director conducted a training session with the new Director of Culinary on the requirements of Regulation 2600.103.e.

Starting the week of 5/25/2026, the Director of Culinary or designee will audit the dry goods storage area three times weekly for 4 weeks, then twice weekly for 4 weeks then weekly for 4 weeks to ensure compliance with Regulation 2600.103.e.

Documentation of training and meetings will be maintained.

Licensee's Proposed Overall Completion Date: *05/29/2026*

Implemented ([redacted] - 07/17/2026)

183a - Original Containers and Injections

13. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On 4/11/2026 at 9:00 AM, one Lorazepam .5 mg tab for Resident 2 was signed out on the controlled drug record

183a Original Containers and Injections (continued)

. This medication was documented as being administered on 4/11/2025 at 2:52 PM.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

On 5/5/26, the staff member who administered the Lorazepam 0.5mg tab to Resident 2 on 4/11/26 was questioned and stated [redacted] gave it at 9am on 4/11/26 but documented it late in the eMAR. This staff member was provided with re education on proper medication administration and this regulation's requirements as well as a counseling on this date. The staff member updated the documentation for the administration of the Lorazepam 0.5mg on 4/11/26 in the eMAR for Resident 2 as a late entry.

On 5/26/26, Memory Care Director who is a Train the Trainer for the PA Medication Administration program will conduct a training with all Med Techs and Nurses on all aspects of the medication program as well as all regulations pertaining to medications.

By 6/10/2026, Division Director of Resident Care and Resident Care Specialist will audit current residents' eMARs for April 2026 and May 2026 to ensure compliance with regulation 2600.183a.

Starting the week of 6/1/2026, DHW, Assistant Director of Health & Wellness (ADHW) or designee will audit 4 resident's eMARs three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks to ensure ongoing compliance with regulation 2600.183a.

Documentation of training and audits will be maintained.

Licensee's Proposed Overall Completion Date: 06/10/2026

Implemented ([redacted] - 07/17/2026)

187b - Date/Time of Medication Admin.

14. 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 Atorvastatin 20 mg tablet, Tamsulosin HCL 0.4 mg capsule, Quetiapine Fumarate 50 mg tab, Vitamin C 500 mg tablet, and Mucinex ER 600 mg tablet. Resident 2's April 2026 medication administration record does not include the initials of the staff person who administered Atorvastatin 20 mg tablet, Tamsulosin HCL 0.4 mg capsule, Quetiapine Fumarate 50 mg tab, Vitamin C 500 mg tablet, and Mucinex ER 600 mg tablet on 4/6/2026 at 8:00 PM.

Resident 3 is prescribed Haloperidol LAC 2 mg/ ml conc. Resident 3's May 2026 medication administration record does not include the initials of the staff person who administered Haloperidol LAC 2 mg/ ml conc on 5/1/2026 at 8:00 PM.

Resident 3 is prescribed Morphine Sulf 100 mg/ 5 ml conc. This medication was signed out on Resident 3's Individual Narcotic Record on 5/1/2026 at 10:00 PM, however Resident 3's May 2026 medication administration record does not include the initials of the staff person who administered Morphine Sulf 100 mg/ 5 ml conc on 5/1/2026 at 10:00 PM.

Repeat Violation: 5/1/2025, 3/6/2025

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

On 5/4/26, the staff member who administered the Atorvastatin 20mg tablet, Tamsulosin HCL 0.4mg capsule, Quetiapine Fumarate 50mg tablet, Vitamin C 500mg tablet and Mucinex ER 600mg tablet to Resident 2 at 8pm

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

was questioned and stated [redacted] did administer those medications on 4/6/26 at 8:15pm, however, [redacted] forgot to document the administration that day. This staff member was provided with re-education on proper medication administration and this regulation's requirements as well as a counseling on this date. The staff member updated the documentation for the administration of these medications on 5/4/26 in the eMAR for Resident 2 as a late entry.
- On 5/4/2026, the staff member who administered the Haloperidol LAC 2 mg/ml concentrate to resident 3 on 5/1/2026 at 8pm was questioned and stated [redacted] did administer that medication on 5/1/2026 at 8pm, however, [redacted] forgot to document the administration that day. This staff member was provided with re-education on proper medication administration and this regulation's requirements as well as a counseling on this date. The staff member updated the documentation for the administration of these medications on 5/4/2026 in the eMAR for Resident 2 as a late entry.
- On 5/4/2026, the staff member who administered the Morphine Sulfate 100mg/5ml concentrate to resident 3 on 5/1/2026 at 10pm was questioned and stated [redacted] did administer that medication on 5/1/2026 at 10pm, however, [redacted] forgot to document the administration that day. This staff member was provided with re-education on proper medication administration and this regulation's requirements as well as a counseling on this date. The staff member updated the documentation for the administration of these medications on 5/4/2026 in the eMAR for Resident 2 as a late entry.
- On 5/26/26, Memory Care Director who is a Train the Trainer for the PA Medication Administration program will be conducting a training with all Med Techs and Nurses on all aspects of the medication program as well as all regulations pertaining to medications.
-By 6/10/2026, Division Director of Resident Care and Resident Care Specialist will audit current residents' eMARs for April 2026 and May 2026 to ensure compliance with regulation 2600.183a.
- Starting the week of 6/1/2026, DHW, ADHW or designee will audit 4 resident's eMARs three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks to ensure ongoing compliance with regulation 2600.187b. - Documentation of training and audits will be maintained.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 07/17/2026)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

Resident 1 is prescribed Allopurinol 100 mg tablet, Aspirin 81 mg tablet, and Escitalopram 20 mg tablet, all scheduled to be administered at 8:00 AM daily. However, Resident 1 was administered Allopurinol 100 mg tablet, Aspirin 81 mg tablet, and Escitalopram 20 mg tablet on 4/9/2026 at 9:36 AM.

Resident 2 is prescribed Famatodine 20 mg tablet, Ferrous sulfate 325 mg tablet, Metformin HCL 500 mg tablet, Levothyroxine 25 mcg tablet, and Repaglinide 1 mg tablet, all scheduled to be administered at 8:00 AM daily. However, Resident 2 was administered Famatodine 20 mg tablet, Ferrous sulfate 325 mg tablet, Metformin HCL 500 mg tablet, Levothyroxine 25 mcg tablet, Repaglinide 1 mg tablet on 4/4/2026 at 9:29 AM.

Resident 3 is prescribed Morphine Sulf 100 mg/ 5 ml conc., take 0.25 ml by mouth every 4 hours (alternate every 2 hours with Haldol). However, Resident 3 was not administered Morphine Sulf 100 mg/ 5 ml conc. on 5/2/2026 at 10:00 PM.

187d - Follow Prescriber's Orders (continued)

Resident 4's prescribed Alprazolam 0.25 mg tab was administered to Resident 3 on 3/7/2026 at 1:00 PM, instead of Resident 3's prescribed Lorazepam 0.5 mg tab.

Resident 4 is prescribed Acetaminophen ER 650 mg caplet, Alprazolam 0.25 mg tablet, Dicyclomine 20 mg tablet, and Levothyroxine 50 mcg tablet, all scheduled to be administered at 8:00 AM daily. However, Resident 4 was administered Acetaminophen ER 650 mg caplet, Alprazolam 0.25 mg tablet, Dicyclomine 20 mg tablet, and Levothyroxine 50 mcg tablet on 4/11/2026 at 10:40 AM.

Resident 5 is prescribed Vitamin B-12 1,000 mcg tablet, Memantine HCL 5 mg tablet, Paroxetine HCL 20 mg tablet, and Paroxetine HCL 10 mg tablet, all scheduled to be administered at 8:00 AM daily. However, Resident 5 was administered Vitamin B-12 1,000 mcg tablet, Memantine HCL 5 mg tablet, Paroxetine HCL 20 mg tablet, and Paroxetine HCL 10 mg tablet on 4/11/2026 at 10:07 AM.

Repeat Violation: 3/6/2025

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

- On 5/5/26, the staff member who administered Resident 1's Allopurinol 100 mg tablet, Aspirin 81 mg tablet, and Escitalopram 20 mg tablet that were scheduled on 4/9/26 at 8:00am was questioned and stated [redacted] administered all these medications timely but signed them out later. This staff member was provided with re-education on proper medication administration and this regulation's requirements as well as a counseling on this date. The staff member updated the documentation for the administration of these medications on 4/9/26 for Resident 1 as a late entry.
- On 5/5/26, the staff member who administered Resident 2's Famotodine 20 mg tablet, Ferrous Sulfate 325 mg tablet, Metformin HCL 500 mg tablet, Levothyroxine 25 mcg tablet, and Repaglinide 1 mg tablet that were scheduled on 4/4/26 at 8:00am was questioned and stated [redacted] administered all these medications timely but signed them out later. This staff member was provided with re-education on proper medication administration and this regulation's requirements as well as a counseling on this date. The staff member updated the documentation for the administration of these medications on 4/4/26 for Resident 2 as a late entry.
- On 5/4/26, the staff member who administered Resident 3's Morphine Sulfate 100 mg/5 ml concentrate, take 0.25 ml by mouth every 4 hours (alternate every 2 hours with Haldol) on 5/2/26 that was scheduled at 10:00pm was questioned and stated [redacted] administered this medication timely but forgot to sign it out. This staff member was provided with re-education on proper medication administration and this regulation's requirements as well as a counseling on this date. The staff member updated the documentation for the administration of these medications on 5/2/26 for Resident 3 as a late entry.
- The Med Tech who administered Resident 4's Alprazolam 0.25 mg tab to Resident 3 on 3/7/2026 at 1:00pm, instead of Resident 3's prescribed Lorazepam 0.5 mg tab realized the error when counting the controlled substances at 3:30pm. [redacted] reported the error and the community submitted a reportable incident to the Department on 3/8/26. Med tech was removed from medication administration duties on 3/8/26 and received a written warning that same day. After successfully completing medication administration retraining which finished on 3/11/26, [redacted] was allowed to resume [redacted] medication administration duties.
- On 5/5/26, the staff member who administered Resident 4's Acetaminophen ER 650 mg caplet, Alprazolam 0.25 mg tablet, Dicyclomine 20 mg tablet, and Levothyroxine 50 mcg tablet which were scheduled on 4/11/26 at 8am was questioned and [redacted] stated [redacted] administered all these medications timely but signed them out later. This staff

187d Follow Prescriber's Orders (continued)

member was provided with re education on proper medication administration and this regulation's requirements as well as a counseling on this date. The staff member updated the documentation for the administration of these medications on 4/11/26 for Resident 4 as a late entry.

The staff member who administered Resident 5's Vitamin B 12 1,000 mcg tablet, Memantine HCL 5 mg tablet, Paroxetine HCL 20 mg tablet, and Paroxetine HCL 10 mg tablet which was scheduled on 4/11/26 at 8am worked [redacted] last shift as a Med Tech on 4/26/26, however, on 5/22/26, [redacted] was provided with re education on proper medication administration and this regulation's requirements. The staff member updated the documentation for the administration of these medications on 4/11/26 for Resident 5 as a late entry.

On 5/26/2026, Memory Care Director who is a Train the Trainer for the PA Medication Administration program will conduct a training with all Med Techs and Nurses on all aspects of the medication program as well as all regulations pertaining to medications.

By 6/10/2026, Division Director of Resident Care and Resident Care Specialist will audit current residents' eMARs for April 2026 and May 2026 to ensure compliance with regulation 2600.183a.

Starting the week of 6/1/2026, DHW, ADHW or designee will audit 4 resident's eMARs three times weekly for 4 weeks then twice weekly for 4 weeks then weekly for 4 weeks to ensure ongoing compliance with regulation 2600.187d. Documentation of training and meetings will be maintained.

Licensee's Proposed Overall Completion Date: *06/10/2026*

Implemented ([redacted] - 07/17/2026)

227h - Support Plan Refuse Sign

16. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident 6 participated in the development of [redacted] support plan on 4/17/2026. The resident was unable and/or refused to sign the support plan. The home did not make a notation regarding the resident's inability and/or refusal to sign.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

On 5/6/26, MCD got resident 6 to sign [redacted] support plan from 4/17/26, which [redacted] was previously unwilling to sign.

On 5/4/26, ED retrained MCD on the requirements of regulation 227h.

By 6/5/26, MCD or designee will audit current resident's RASPs to ensure they have been signed or if the resident is unable and/or refused to sign, that it is documented per the requirements in regulation 227h. If any RASPs are found to be out of compliance, they will be addressed immediately.

Starting the week of 6/1/2026, MCD or designee will audit 4 RASPs weekly for 3 months to ensure there is a signature or documentation regarding the resident being unable and/or refusing to sign for ongoing compliance with regulation 2600.227h.

Documentation of training and audits will be maintained.

Licensee's Proposed Overall Completion Date: *06/05/2026*

Implemented ([redacted] - 07/17/2026)

231e - No Objection Statement

17. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident 2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident 7 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept ([redacted] - 06/01/2026)***

- On 5/4/26, MCD added the following statement to Resident 2's RASP: "No objections were noted by resident or responsible party for admission to SDCU."
- On 5/4/26, MCD added the following statement to Resident 7's RASP: "No objections were noted by resident or responsible party for admission to SDCU."
- On 5/28/2026, a new residency agreement was created for Hidden Meadows on the Ridge – The Laurels, which has the following statement listed at the top of page 2, "You and your Responsible Person acknowledge and agree that your admission to, or transfer into, the Community's secured dementia care unit is appropriate based on your assessed needs. You and your Responsible Person further acknowledge that you have no objection to your admission or transfer to the secured dementia care unit and understand the purpose, features and safety measures associated with the secured environment." As of 6/1/26, this agreement will be used for all admissions or transfers to the secured dementia care unit.
- By 6/5/2026, MCD or designee will audit current residents' RASPs to ensure statement is documented that neither the resident nor [redacted] designated person has objected to the resident residing in a secured dementia care unit. If any RASPs are found to be out of compliance, they will be addressed immediately.
- Starting the week of 6/1/2026, MCD or designee will audit 4 RASPs weekly for 3 months to ensure there is a statement documenting that neither the resident nor his/[redacted] designated person has objected to the resident residing in a secured dementia care unit for ongoing compliance with regulation 2600.231e.
- Documentation of training and audits will be maintained.

Licensee's Proposed Overall Completion Date: *06/05/2026*

Implemented ([redacted] - 07/17/2026)