

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

October 21, 2026

[REDACTED], MANGER
WYNCOTE CARE LLC
208 FERNBROOK AVENUE
WYNCOTE, PA, 19095

RE: WYNCOTE CARE CENTER
208 FERNBROOK AVENUE
WYNCOTE, PA, 19095
LICENSE/COC#: 15264

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/07/2026, 05/08/2026 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: WYNCOTE CARE CENTER

License #: 15264

License Expiration: 04/29/2027

Address: 208 FERNBROOK AVENUE, WYNCOTE, PA 19095

County: MONTGOMERY

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: WYNCOTE CARE LLC

Address: 208 FERNBROOK AVENUE, WYNCOTE, PA, 19095

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-1

Date: 11/18/1992

Issued By: Dept of Health

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 19

Waking Staff: 14

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal

Exit Conference Date: 05/08/2026

Inspection Dates and Department Representative

05/07/2026 - On-Site: [REDACTED]

05/08/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 45

Residents Served: 16

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 3

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 16

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 3

Have Physical Disability: 3

Inspections / Reviews

05/07/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 05/31/2026

06/01/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/01/2026

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 06/06/2026

Inspections / Reviews (*continued*)

06/25/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/01/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 07/02/2026

10/21/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/01/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

17 - Record Confidentiality**1. Requirements**

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 5/7/2026, at 9:28 AM, multiple binders containing private resident information were unlocked, unattended, and accessible in the doctor's office.

Repeat Violation: 2/24/2025

Plan of Correction**Accept () - 06/25/2026)**

The doctor's office door was closed and locked immediately on 05/07/26. All resident binders containing PHI were secured in a locked office/cabinet accessible only to authorized staff.

All PCH staff were educated by the Administrator on importance of protecting resident records by securing the Doctor's office when not in use by staff or authorized agencies/responsible party, with a completion date of 05/31/2026.

The Administrator/Designee will implement daily documented audit on 05/28/2026 for 30 days and areas of non-compliance will be addressed at QAPI.

Licensee's Proposed Overall Completion Date: 06/28/2026

Implemented () - 10/21/2026)**25a - Written Contract and Review****2. Requirements**

2600.

- 25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident 1, admitted (), did not have a resident-home contract in their record on 5/8/2026.

Plan of Correction**Accept () - 06/25/2026)**

Resident 1 original admission agreement was uploaded in the EMAR system in their file. The Admissions Director was in-serviced by the Administrator on ensuring all new admits have an admission agreement in place and easily accessible by all authorized agencies, residents, and responsible parties. A secondary audit by the Administrator/Designee to verify completion of admission agreement is now in place to monitor sustained compliance, effective 06/01/2026.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026)

51 - Criminal Background Check**3. Requirements**

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff Person A, whose first day of employment was [REDACTED], and who is not a resident of the state of Pennsylvania, did not have a completed FBI background check in their record.

Plan of Correction**Accept ([REDACTED] - 06/25/2026)**

Staff person A will get an FBI fingerprinting background check immediately or as soon as applicable to ensure compliance with background check protocols for out-of-state residency staff members.

The HR Coordinator was in-serviced by the Administrator on checking and ensuring all out of state staff members to get an FBI fingerprinting done as part of background check verification for employment.

The HR Coordinator will audit effective 06/01/2026 all staff who lived out of state in prior 2 years and are subject to the FBI fingerprint background checks to maintain an updated staff file that is compliant with background employment verification checks. HR checklist before first day of work will be implemented to ensure compliance with hiring procedures. The Administrator/Designee will continue to monitor for compliance for three months or until substantial compliance is met.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented ([REDACTED] - 10/21/2026)**65a - FS Orientation 1st Day****4. 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 A, whose first day of work was [REDACTED] did not receive orientation on the following topics: evacuation procedures, 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, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, and/or telephone use

65a FS Orientation 1st Day (continued)

and notification of emergency services.

Staff Person B, whose first day of work was [REDACTED], did not receive orientation on the following topics: evacuation procedures, 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, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, and/or telephone use and notification of emergency services.

Plan of Correction

Accept [REDACTED] - 06/25/2026)

Staff person A and B both received a complete and signed orientation forms on the following required topics by the Staffing Educator/Designee.

The HR staff was in serviced by the Administrator on ensuring a complete orientation including the following mandatory topics for all new hires are done before being released to work. The HR Coordinator/Designee will monitor effective 06/01/2026 for compliance with the mandatory orientation for new staff for one quarter or until substantial compliance is met. Any areas of non compliance will be reported to the quarterly QAPI committee and addressed as needed.

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

Implemented [REDACTED] - 10/21/2026)

65b - Rights/Abuse 40 Hours**5. 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 B completed [REDACTED] 40th scheduled work hour on prior to [REDACTED]. However, as of 5/8/2026, this staff person did not complete training in the following topics: emergency medical plan.

Plan of Correction

Accept [REDACTED] - 06/25/2026)

Staff B will have a complete training in the following topics: emergency medical plan by the Staff Educator/Designee.

A full house audit of all new hire staff files was completed by the HR/Designee on 05/31/26 to ensure staff files include complete training plan.

The Staff Educator/Designee was in serviced by the Administrator on ensuring a complete training covering emergency medical plan is conducted for all new hire staff.

65b - Rights/Abuse 40 Hours (continued)

The HR Coordinator/designee effective 06/01/2026 will audit and monitor for compliance with complete training including emergency medical plan is conducted for one quarter and any areas of non-compliance will be reported to the quarterly QAPI committee.

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

Implemented () - 10/21/2026)

65f - Training Topics**6. 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 C did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, and safe management techniques during training year 1/1/2025 through 12/31/2025.

Direct Care Staff Person D did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, and safe management techniques during training year 1/1/2025 through 12/31/2025.

Plan of Correction

Accept () - 06/25/2026)

Direct Care Staff person C will receive training from the Staff Educator/Designee in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, and safe management techniques by 05/31/2026.

Direct Care Staff Person D will receive training from the Staff Educator/Designee in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as

65f - Training Topics (continued)

prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, and safe management techniques by 05/31/2026.

All direct care staff training records for 2025 were audited and any missing training was completed. 2026 annual training calendar and monthly compliance review will be conducted by Administration/Designee. The Staff Educator/Designee will perform an ongoing audit effective 06/01/2026 of all direct care staff files for compliance with the mandatory trainings for one year or until substantial compliance is met. Any areas of non-compliance will be reported to the quarterly QAPI committee for tracking and trending and corrected as needed.

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

Implemented () - 10/21/2026)

65g - Annual Training Content**7. 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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, and falls and accident prevention during training year 1/1/2025 through 12/31/2025.

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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, and falls and accident prevention during training year 1/1/2025 through 12/31/2025.

Plan of Correction

Accept () - 06/25/2026)

Staff Person C and Staff person D will receive training from the Maintenance Director/Designee 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

65g - Annual Training Content (continued)

rights, and falls and accident prevention by 05/31/2026.

All staff training records for 2025 were audited and any missing trainings completed. 2026 annual training calendar and monthly compliance review to be implemented by the Administration/Designee. The Staff Educator/Designee effective 06/01/2026, will audit staff files for compliance with the mandatory trainings monthly for one year or until substantial compliance is met. Any areas of non-compliance will be reported to the quarterly QAPI committee for tracking and trending and corrected as needed.

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

Implemented () - 10/21/2026)

65i - Training Record**8. Requirements**

2600.

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

Description of Violation

Staff Person E's orientation training record does not include the date and/or source.

Plan of Correction

Accept () - 06/25/2026)

Staff person E will have a complete training record to include date and/or source. The Staffing Educator/Designee will educate staff person E and verify completion of the training and topics covered in the orientation process. The Staff Educator/HR were educated on required training record elements.

The Staffing Educator/Designee will audit effective 06/01/26 all staff files to ensure a complete record to include date and source for all records. Any areas of non-compliance will be reported to the quarterly QAPI committee and addressed.

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

Implemented () - 10/21/2026)

66a - Staff Training Plan**9. Requirements**

2600.

66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for 1/1/2026 through 12/31/2026.

Plan of Correction

Accept () - 06/25/2026)

The home will have a staff training plan for the year 2026 by 06/01/2026. The Staffing Educator/Designee was in-serviced by the Administrator to develop and provide a staff training plan for 2026 and annually thereafter.

The Administrator/Designee will monitor the annual training plan on 06/01/26 and track its progress for compliance, any areas of non-compliance will be reported to the quarterly QAPI committee.

Licensee's Proposed Overall Completion Date: 06/01/2026

66a Staff Training Plan (continued)

Implemented () - 10/21/2026

101j7 Lighting/Operable Lamp

10. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

*Resident 2 does not have access to a source of light that can be turned on/off at bedside.**Resident 3 does not have access to a source of light that can be turned on/off at bedside.*

Plan of Correction

Accept () - 06/25/2026

*Resident 2 and 3 now have a source of light that can be turned on/off at bedside as of 05/22/2026.**The maintenance director was educated by the Administrator on ensuring that there is a source of lighting that can be on/off and available at bedside for residents.**The facility implemented weekly room check rounds on 06/01/26 to ensure proper bedside lighting is available and operable for residents. The audits will be reported in morning report weekly for 4 weeks then ongoing as needed and reports sent to QAPI.*

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026

130f Testing Smoke Detectors

11. Requirements

2600.

130.f. Smoke detectors and fire alarms shall be tested for operability at least once per month. A written record of the monthly testing shall be kept.

Description of Violation

The home's smoke detectors and fire alarms were not tested during the months of 6/2025, 9/2025, 11/2025, 1/2026, 3/2026 and 4/2026.

Plan of Correction

Accept () - 06/25/2026

*The Home's smoke detectors and fire alarms were tested with no operable deficiencies noted on the monthly fire drill test on 05/28/26. A monthly fire alarm/smoke detector test was initiated as of 05/28/26 to ensure operability. A written record of the monthly testing and calendar with Administrator/Designee signoff will be kept by the Maintenance Director/Designee**The Maintenance Director was in-serviced by the Administrator to ensure fire alarms/smoke detectors to be tested monthly and a record documented.**The Administrator/Designee will monitor for compliance monthly as of 06/01/26, and any areas of non-compliance will be addressed immediately and reported to QAPI.*

130f - Testing Smoke Detectors (continued)

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

Implemented () - 10/21/2026)

132a - Monthly Fire Drill**12. Requirements**

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the months of 6/2025, 9/2025, 11/2025, 1/2026, 3/2026 and 4/2026.

Plan of Correction

Accept () - 06/25/2026)

Facility conducted an unannounced fire drill on 05/28/26. Facility adopted DHS-compliant monthly unannounced fire drill form. A Monthly drill log will be reviewed by the Administrator.

The Maintenance Director was in-serviced by the Administrator to implement fire drills unannounced monthly. The Administrator/Designee will monitor for compliance monthly as of 06/01/26, and any areas of non-compliance will be addressed immediately and reported to QAPI.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026)

132b - Safety Inspection/Fire Drill**13. Requirements**

2600.

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

Description of Violation

The last fire safety inspection and drill observed by a fire safety expert was conducted on 12/17/2025. The previous fire safety inspection and drill observed by a fire safety expert was conducted on 8/28/2024.

Plan of Correction

Accept () - 06/25/2026)

The Maintenance Director scheduled an annual fire safety inspection and fire drill with the County and local Fire OEM office 06/01/26. The maintenance director was in-serviced by the Administrator on ensuring a fire safety inspection and fire drill be conducted by a fire safety expert annually.

The Administrator/Designee will monitor for compliance on 06/01/26 and thereafter annually and non-compliance will be addressed and reported to QAPI.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026)

132c - Fire Drill Records**14. Requirements**

2600.

132c - Fire Drill Records (continued)

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

Description of Violation

The fire drill record for the drill conducted on 5/29/2025 does not include the exit route used, the number of residents in the home at the time of the drill, and the number of residents evacuated.

The fire drill record for the drill conducted on 7/30/2025 does not include date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, problems encountered and whether the fire alarm or smoke detector was operative.

The fire drill record for the drill conducted on 8/31/2025 does not include date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, problems encountered and whether the fire alarm or smoke detector was operative.

Repeat Violation: 2/24/2025

Plan of Correction

Accept () - 06/25/2026

Facility conducted a DHS compliant fire drill on 05/28/26 drill form listing every required field: date, time, evacuation time, exit route, residents in home, residents evacuated, staff participating, problems, alarm/smoke detector operability.

The Maintenance Director was in-serviced by the Administrator to implement a new fire drill record and process and documentation of such procedures.

The Administrator/Designee will monitor for compliance on 06/01/26 monthly for 6 months and QAPI tracking.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026

132d - Evacuation**15. 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 10/31/2025 at 1:45 PM, residents evacuated to a public thoroughfare or public area. On that date, the home did not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds on 10/31/2025 at 1:45 PM, with an evacuation time of 12 minutes. The previous maximum safe evacuation time specified in writing by a fire safety expert was 8 minutes and was documented on 8/28/24.

132d - Evacuation (continued)

Plan of Correction

Accept () - 06/25/2026

The maintenance director reached out to the County OEM and local Fire Department to schedule an outside fire-safety expert fire inspection and drill on 06/01/2026.

The Maintenance Director was in-serviced by the Administrator on ensuring a fire drill to have a designated evacuation area specified in writing within the past year and to be within the maximum safe evacuation time specified in writing by a fire safety expert.

The Home will repeat drill if evacuation exceeds allowed time specified by the fire safety expert.

The Administrator/designee will monitor for compliance on 06/01/26 every year and areas of non-compliance will be addressed and reported to quarterly QAPI.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026

132e - Fire Drill Sleeping Hours

16. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home has not held any fire drills during sleeping hours.

Plan of Correction

Accept () - 06/25/2026

A fire drill was conducted during sleeping hours on 05/29/26 with the alarm system activated.

The Maintenance Director was in-serviced by the Administrator on conducting fire drills every 6 months during sleeping hours with the alarm on. Calendar reminders every 6 months were implemented as part of QAPI.

The Administrator/Designee will monitor for compliance on 06/01/26 every 6 months and areas of non-compliance will be addressed and reported to QAPI or until substantial compliance is met.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026

141a - Medical Evaluation

17. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

As of 5/8/2026, Resident 4 who was admitted () did not have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department in their record.

Plan of Correction

Accept () - 06/25/2026

Resident 4's DHS medical evaluation form was completed and placed in the PCH resident record to ensure

141a - Medical Evaluation (continued)

compliance with admission requirements. All residents' records were reviewed to verify current DME completed and properly documented.

The Administrator/Designee will monitor admission documentation on 06/01/26 with admissions to ensure all required DME are completed within the timeframes or until substantial compliance is met.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026)

141a 1-10 Medical Evaluation Information**18. Requirements**

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 1's medical evaluation, signed on [REDACTED] did not include an evaluation date, immunization history, health status, and/or whether or not the resident's needs can be safely met at a Personal Care Home.

Resident 3's medical evaluation, dated [REDACTED], did not include a general physical examination by a physician, physician's assistant or nurse practitioner, health status, cognitive functioning, and/or whether or not the resident's needs can be safely met at a Personal Care Home.

Plan of Correction

Accept () - 06/25/2026)

Resident 1 and Resident 3 forms were corrected to include evaluation date, immunization history, health status, physical exam, cognitive function, and whether needs can be safely met.

New admission checklist requiring all DHS form fields before admission or within allowed timeframe was implemented by administration for compliance.

Administrative Staff/Designee will be monitoring on 06/01/26 for ongoing compliance with medical evaluations to ensure all required sections are fully completed and maintained in resident records or until substantial compliance is met.

141a 1-10 Medical Evaluation Information (continued)

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026

183d - Prescription Current

19. 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 5/7/2026, Mometasone Cream 0.1% prescribed for Resident 3, was in the home's medication cart; however, this medication is not listed on Resident 3's current medication orders.

Mupirocin 2% ointment prescribed for Resident 5, was in the home's medication cart; however, this medication is not listed on Resident 5's current medication orders.

Plan of Correction

Accept () - 06/25/2026

The medications Mometasone and Mupirocin were removed from cart until current orders were obtained. Weekly medication cart/order reconciliation x8 weeks were initiated as part of ongoing audit and monitoring for compliance by the DON/Designee on 06/01/26. Any medication discrepancies will be corrected, and audits will be reported to the QAPI for tracking.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026

185a - Implement Storage Procedures

20. 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 5/7/2026 at 3:04 PM, Resident 5's Tramadol 50 mg tab controlled substance log indicated a quantity of 20 tablets available, however there were only 19 tablets in the Tramadol 50 mg tab bubble pack. Staff did not document the removal of Resident 5's prescribed Tramadol 50 mg tab from the medication cart, when the medication was administered on 5/7/2026 at 8:30 AM.

185a Implement Storage Procedures (continued)

On 5/7/2026 at 3:06 PM, Resident 5's Lorazepam 0.5 mg tab controlled substance log indicated a quantity of 28 tablets available, however there were only 27 tablets in the Lorazepam 0.5 mg tab bubble pack. Staff did not document the removal of Resident 5's prescribed Lorazepam 0.5 mg tab from the medication cart, when the medication was administered on 5/7/2026 at 8:30 AM.

According to the home's medication policy, "controlled substances shall be stored in separately locked compartments and documented on individual controlled substance records, including beginning count, administrations and shift to shift counts."

Plan of Correction

Accept () - 06/25/2026)

The Home investigated the discrepancy, count corrected/reconciled, physician/pharmacy notified as needed, and staff responsible was re educated on medication clarification procedures. A shift to shift narcotic count audit was initiated on 06/01/26 for weeklyx4 and were implemented by nursing/designated staff. Ongoing monitoring for compliance will be observed by the DON/Designee.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026)

187b - Date/Time of Medication Admin.**21. 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 3 is prescribed Basaglar inj 100 unit, inject 12 units subcutaneously at bedtime. Resident 3's April 2026 medication administration record does not include the initials of the staff person who administered Basaglar inj 12 units on 4/10/2026 at 9:00 PM.

Resident 5 is prescribed Tamsulosin HCL Oral Capsule 0.4 mg, give 1 capsule by mouth in the evening. Resident 5's April 2026 medication administration record does not include the initials of the staff person who administered Tamsulosin HCL Oral Capsule 0.4 mg on 4/10/2026 at 5:00 PM.

Resident 5 is prescribed Lorazepam Oral Tablet 1 mg, give 1 tablet by mouth at bedtime. Resident 5's April 2026 medication administration record does not include the initials of the staff person who administered Lorazepam Oral Tablet 1 mg on 4/10/2026 at 9:00 PM.

Plan of Correction

Accept () - 06/25/2026)

The DON reviewed the MAR omissions and documented a late entry clarification according to policy where

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

appropriate. Medication documentations audit was completed for all residents by the DON/Designee and supervisory staff/Designee will conduct ongoing MAR audit on 06/01/26 weeklyx4 for sustained compliance, any issues reported to QAPI for tracking.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026)

191 - Resident Right to Refuse**22. Requirements**

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident 3, admitted () has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Accept () - 06/01/2026)

The resident was educated on the right to question or refuse medication if medication error is suspected. Documentation of educations was completed and placed in the resident records. All current residents educated or re-educated on right to question/refuse medication if they believe there may be an error to ensure required medication rights educations is completed and documented in each resident record and added to the admission packet. Staff were re-educated on resident medication rights and documentation requirements by the DON/Designee to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented () - 10/21/2026)

224a - Preadmission Screen Form**23. Requirements**

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 4 was admitted to the home on () however, as of 5/8/2026 there was no documentation that Resident 4's preadmission screening was completed.

Plan of Correction

Accept () - 06/25/2026)

Resident 4's preadmission screen was completed and placed in the record. All resident admission records were reviewed to ensure required pre-admission screen are completed within the required timeframe. Staff were re-educated on admissions documentations requirements by the DON/Designee and administration will conduct ongoing audits on 06/01/26 to ensure continued compliance and prevent future deficiencies.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented () - 10/21/2026)

225a - Assessment 15 Days

24. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for Resident 4, who was admitted to the home on [REDACTED].

Plan of Correction**Accept [REDACTED] - 06/25/2026)**

Resident 4 assessment completed on DHS form and placed the assessment in the resident's record. All resident files were reviewed to ensure initial assessment are completed within the required timeframes. Staff were re-educated on admission and assessment documentation requirements by the DON/Designee and admission tracking log reviewed weekly by the Administrator/Designee on 06/01/26.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented [REDACTED] - 10/21/2026)**225c Additional Assessment****25. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 1's current assessment was completed on [REDACTED] However, the resident's previous assessment was completed on [REDACTED]

The assessment for Resident 1, dated [REDACTED] does not indicate whether or not the resident has a service need for vision, hearing or communication.

The assessment for Resident 3, dated [REDACTED], does not indicate whether or not the resident has a service need for agitation or aggression.

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

The Home updated and completed the resident's annual assessment to include all required information including vision, hearing, communication needs, agitation and aggression status. All resident assessments were reviewed for accuracy and timely completion in accordance with regulation and requirements. Staff were re-educated on assessment documentation requirements by the DON/Designee. Annual assessment calendar with 30/60 day alerts were implemented to ensure an annual tracking system for compliance.

Licensee's Proposed Overall Completion Date: 05/31/2026

Implemented [REDACTED] - 10/21/2026)**227a Support Plan 30 Days****26. Requirements**

2600.

227a Support Plan 30 Days (continued)

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident 4 was admitted on [REDACTED] however, the resident's initial support plan had not been completed as of 5/8/2026.

Plan of Correction**Accept ([REDACTED] - 06/25/2026)**

Resident 4 support plan completed, implemented, and communicated to direct care staff. Support plan audit for all residents done to ensure support plans are completed within the required timeframe. Staff were re educated on support plan requirements by the DON/Designee and administration will conduct ongoing audits on 06/01/26 monthlyx3 to ensure continued compliance and prevent future deficiencies or until substantial compliance is met.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented ([REDACTED] - 10/21/2026)**251b - Record Entries Legible****27. 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

Correction fluid was used on Resident 3's medical evaluation form dated [REDACTED]

Plan of Correction**Accept ([REDACTED] - 06/25/2026)**

The Home implemented a new policy to prohibit correction fluid for all documentations. Errors must be corrected with single line through, date, initials/signature, and reason if needed. Staff were re educated on proper documentation standards and acceptable methods for correction errors by the DON/Designee. Monthly audits on 06/01/26 initiated and ongoing until substantial compliance is met.

Licensee's Proposed Overall Completion Date: 06/01/2026

Implemented ([REDACTED] - 10/21/2026)