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

July 13, 2026

[redacted], NURSING HOME ADMINISTRATOR
470 MANOR OPERATING LLC
490 MANOR AVENUE
DOWNINGTOWN, PA, 19335

RE: ST. MARTHA VILLA FOR INDEPENDENT & RETIREMENT LIVING
490 MANOR AVENUE
DOWNINGTOWN, PA, 19335
LICENSE/COC#: 14108

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/11/2026, 05/12/2026 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: *ST. MARTHA VILLA FOR INDEPENDENT & RETIREMENT LIVING* **License #**: *14108* **License Expiration**: *08/01/2026*

Address: *490 MANOR AVENUE, DOWNINGTOWN, PA 19335*

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

Administrator

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

Legal Entity

Name: *470 MANOR OPERATING LLC*

Address: *490 MANOR AVENUE, DOWNINGTOWN, PA, 19335*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/04/2021* **Issued By**: *CWOPA L&I*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/12/2026*

Inspection Dates and Department Representative

05/11/2026 - On-Site: [redacted]

05/12/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *135* **Residents Served**: *47*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Carlson* **Capacity**: *35* **Residents Served**: *18*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *47*

Diagnosed with Mental Illness: *4*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *29*

Have Physical Disability: *0*

Inspections / Reviews

05/11/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/25/2026*

Inspections / Reviews *(continued)*

06/24/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/12/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/26/2026*

06/25/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/12/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/13/2026*

07/13/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/12/2026*

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

On [redacted] at approximate [redacted] resident #1 was agitated and assaulted resident #2 by slapping them in the face. Staff person A observed this incident. This incident was reported to staff person B. However, the allegation of abuse was not reported to the local area agency for aging.

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

1. Clinical Director filled out appropriate OAPS form and phoned OAPS to report resident abuse immediately following survey on 5/13/2026.
2. Administrator checked the previous 90 days of reportables to ensure all reports were reported correctly on or before 6/30/2026.
3. Administrator educated Clinical Director regarding reporting abuse to OAPS immediately following an incident on 5/13/2026.
4. Administrator or designee will complete a weekly audit ensuring all abuse reporting is reported appropriately to OAPS. The audit will be conducted once a week for a month. The audit results will be reviewed at the QAPI meeting on or before 7/10/2026.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] resident #3 had an unwitnessed fall that required hospitalization. The home did not report this incident to the Department until 05/11/26 at 10:00 am.

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

1. Administrator acknowledged immediately following survey on 5/13/26 that the report was 45 minutes past the timeframe. Administrator is unable to correct the cited deficiency, but no harm noted to any resident.
2. Administrator checked the previous 90 days of reportables to ensure they were reported in the correct timeframe on or before 6/30/2026.
3. Administrator educated Clinical Director regarding the regulation and the importance of reporting within the 24hr timeframe on or before 7/10/2026.
4. Administrator or designee will complete a weekly audit ensuring reportables are reported within the 24hr timeframe. The audit will be conducted once a week for a month. The audit results will be reviewed at the QAPI meeting on or before 7/10/2026.

16c - Written Incident Report *(continued)*

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented (- 07/13/2026)

28f - Resident's Funds and 30-day Refund

3. Requirements

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident #4 was discharged on [redacted] The home did not provide the required refund until [redacted]

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

1. Administrator verified on 5/13/26 that Resident 4 was not provided with the refund in 30 days.
2. Administrator or designee checked the previous 90 days of discharges/deaths to ensure refunds were given in the correct timeframe on or before 6/30/2026.
3. Administrator educated business office manager on the regulation and importance of refunding residents/POA's within 30 days on or before 7/10/2026.
4. Administrator or designee will complete a weekly audit ensuring all refunds are given within the 30 day timeframe. The audit will be conducted once a week for a month. The audit results will be reviewed at the QAPI meeting on or before 7/10/2026.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented (- 07/13/2026)

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

On [redacted] resident #2 was putting a puzzle together with staff person A. After finishing the puzzle, resident #2 walked down the hallway to go to their bedroom. Resident #1 jumped in front of resident #2 acting aggressive and slapped resident #2 in the face twice. This incident was witnessed by staff person A. Staff person A who ran and got between the two residents and was able to separate them.
Resident #1's progress notes indicate there was an altercation with another resident in [redacted]. Resident #1's support plan dated [redacted] states the resident can become aggressive when people enter their room or are in [redacted] "seat." According to staff interviews resident #2 was sitting in the seat the resident #1 usually sits in during activities. The home was aware of resident #1's aggression toward the residents.

42b Abuse *(continued)*

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

1. Administrator and Clinical Director reviewed RASP's for Resident 1 and Resident 2 to ensure proper assessment and monitoring were completed immediately following survey on 5/13/26.
2. Clinical Director reviewed memory care resident's records to ensure precautions are being taken to avoid resident to resident contact on or before 6/30/26.
3. Clinical Director educated nursing staff regarding this regulation and the importance of preventing resident to resident contact on or before 7/10/2026.
4. Clinical Director or designee will perform an audit of all incoming memory care residents to ensure proper precautions are taken to avoid resident to resident contact. The audit will be conducted once a week for a month. The audit will be reviewed at the QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

62 - Contact List

5. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

The home's administrator, maintains a list of staff persons that does not include staff persons C and D who are agency staff.

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

1. HR Director reviewed staff including ancillary staff ensuring names, addresses, and telephone numbers were current and complete immediately following survey on 5/13/26.
2. HR Director reviewed the previous 90 days of staff and ancillary staff members to ensure the contact list is updated and current on or before 6/30/2026.
3. Administrator educated HR Director on this regulation and the importance of having a current and complete listing of staff and ancillary staff on or before 7/10/2026.
4. HR Director or designee will complete an audit of all incoming staff and ancillary staff to ensure we are capturing the information needed to maintain our current list. The audit will be conducted once a week for a month. The audit results will be reviewed at the QAPI meeting on or before 7/10/2026.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

63a - First Aid/CPR Training

6. Requirements

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

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

Description of Violation

On 05/01/26 and on 05/02/26, from 11:00 pm to 7:00 am, 47 residents were present in the home. During this time no staff persons were present in the home were certified in first aid, obstructed airway techniques, and CPR.

Repeated Violation - 05/07/2025, et al.

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

1. Administrator immediately following the survey, adjusted staff schedules to ensure at least one staff person for every 50 residents was First aid/CPR certified on 5/13/2026.
2. Administrator reviewed current staff records to ensure First aid/CPR certifications were up to date on or before 6/30/2026.
3. Administrator or designee educated HR Director and Scheduler regarding this regulation and the importance of having 1 certified staff in the building per every 50 residents on or before 7/10/2026.
4. Administrator or designee will complete an audit of all incoming new staff to ensure continued compliance with First Aid/CPR. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented (- 07/13/2026)

65b - Rights/Abuse 40 Hours

7. 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 E completed 40th scheduled work hour on However, this staff person did not complete training in the following topics: resident rights, and emergency medical plan.

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

1. Human Resources Director provided staff person E all required training following survey on or before 5/13/26
2. Human Resources Director reviewed staff records for the previous 90 days to ensure required training was provided on or before 6/30/2026.
3. Administrator or designee educated Human Resources Director and Clinical Director regarding this regulation and the importance of having this training completed on or before 7/10/2026.
4. HR Director or designee will complete an audit of new staff to ensure they receive the required training at orientation. This audit will be conducted once a week for a month. The audit results will be reviewed at the QAPI meeting on or before 7/10/26.

65b Rights/Abuse 40 Hours *(continued)*

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

65e - 12 Hours Annual Training

8. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff persons F and G received 0 hours of annual training in training year 2025.

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

1. Administrator reviewed direct care staff persons F and G to ensure the required training was completed immediately following survey on 5/13/26.
2. Administrator or designee reviewed the last 90 days of staff records to ensure all training has been updated and completed on or before 6/30/2026.
3. Administrator or designee educated Clinical Director of this regulation and the importance of staff receiving 12 hours of annual training on or before 7/10/2026.
4. Administrator or designee will complete an audit of incoming staff to ensure annual training is completed. This audit will be conducted once a week for a month. The audit results will be reviewed at the QAPI meeting on or before 7/10/2026.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

85a - Sanitary Conditions

9. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 05/12/26, at approximately 12:00 pm, trash bags were observed lined up in the first floor hallway, in front of the resident's apartment.

On 05/12/26, at approximately 2:00 pm, resident #3's chair and floor had a brown stain on them. Resident #3 indicated that the brown substance was chocolate and mentioned that the spill had been present for a couple of days. The home was notified about the issue.

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

1. Housekeeping Director ensured first floor hallways were free and clear of trash and Resident 3's chair and floor were shampooed immediately following survey on or before 5/13/2026.

85a - Sanitary Conditions (continued)

2. Administrator or designee checked PC carpets and furniture to ensure all were in good condition and hallways were free and clear of trash immediately following survey on 5/13/26.
3. Administrator or designee educated Housekeeping Director regarding the importance of keeping sanitary conditions on or before 7/10/2026.
4. Housekeeping Director will complete an audit ensuring hallways are free and clear of trash and housekeepers are inspecting furniture and carpets for stains when they are in resident rooms for scheduled housekeeping. This audit will be conducted once a week for a month. The audit results will be reviewed at the QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

85e - Trash Outside Home

10. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 05/11/26, the lid on the dumpster outside was open with trash inside. The recycling dumpster was missing a door.

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

1. Maintenance Director closed dumpster lid and also ordered a new dumpster door to replace the one that was damaged immediately following survey on 5/13/26.
2. Administrator visited dumpster locations on the property to ensure lids were closed and doors in good condition on or before 7/10/2026.
3. Administrator or designee educated Maintenance staff regarding this regulation and the importance of keeping dumpster lids closed and door good repair on or before 7/15/2026.
4. Maintenance Director or designee will complete an audit to ensure dumpster lids remain closed and door remain in good repair. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

101j3 - Bed/Linens/Pillows/Blankets

11. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The bed for resident #5 does not have a pillow.

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

1. Clinical Director provided Resident 5 with a pillow immediately following survey 5/13/26.

101j3 Bed/Linens/Pillows/Blankets (continued)

2. Clinical Director rounded PC to ensure residents had bed linens, pillows, and blankets immediately following survey on 5/13/26.
3. Clinical Director or designee educated nursing staff on this regulation and the importance of ensuring the residents have a pillow, bed linens, and blankets all in good repair on or before 7/10/2026.
4. Clinical Director or designee will complete an audit to ensure PC residents have pillows, bed linens, and blankets and that they are in good repair. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

104b - Dishes/Glassware/Utensils

12. Requirements

2600.
104.b. Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

Description of Violation

The home does not provide utensils when meals are delivered to the resident's room.

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

1. Administrator will make sure the home provides utensils when meals are delivered to resident rooms immediately following survey on 5/13/26.
2. Administrator ensured all carts were equipped with utensils for meals being delivered to resident rooms on 5/13/2026.
3. Administrator educated kitchen staff on this regulation and the importance of delivering meals to resident rooms with utensils being provided 7/10/2026.
4. Administrator or designee will complete an audit to ensure PC residents who are having meals delivered to their rooms are being provided with utensils. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

105f - Labeling/Return of Clothes

13. Requirements

2600.
105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

Description of Violation

The home does not have a system to safeguard resident laundry from loss. Resident #6 reported that their bathmat is missing and it has not been returned within 24 hours.

105f Labeling/Return of Clothes *(continued)*

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

1. Administrator ordered bathmat for Resident 6 immediately following survey on 5/13/26.
2. Administrator met with Housekeeping Director to ensure procedure was in place to safeguard residents' laundry from loss on or before 6/30/26.
3. Administrator educated Housekeeping Director on this regulation and the importance of safeguarding residents' laundry from loss on or before 7/10/2026.
4. Housekeeping Director or designee will complete an audit to ensure there is no misplacement of laundry from residents. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

105g - Lint Removal and Duct Cleaning

14. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 05/11/26, there was a significant accumulation of lint, approximately 5 inches, in the lint trap of the 2nd floor laundry room. There were no clothes in the dryer at the time.

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

1. Administrator immediately inspected the 2nd floor lint traps to ensure all lint was removed on 5/11/26.
2. Administrator rounded facility to check dryers to ensure there was no build up of lint on 5/13/26.
3. Administrator educated housekeeping and nursing staff regarding this regulation and the importance of cleaning lint traps after every use on or before 7/10/2026.
4. Administrator or designee will create and audit to ensure lint traps are being cleaned regularly. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

125a - Combustible Storage

15. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

The Pro Block primer, which has a flammable warning label stating, "extremely flammable; keep away from heat, sparks, and open flame," was stored near the boiler in the boiler room.

125a Combustible Storage *(continued)*

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

1. Maintenance Director checked to ensure primer was removed from boiler room immediately following survey on 5/13/26.
2. Maintenance Director checked all areas near heat sources or hot water heaters to ensure there were no combustible items on 5/13/26.
3. Administrator educated Maintenance staff on this regulation and the importance of making sure there are no combustible items being stored or kept near heat sources or hot water heaters on or before 7/10/2026.
4. Maintenance Director or designee will create and audit to ensure there are no combustible items being stored or kept near heat sources or hot water heaters. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

132h - Designated Meeting Place

16. 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 04/27/26 at 6:00 pm, all residents did not evacuate to a designated meeting place away from the building or within the fire safe area. There were 45 residents in the home and only 38 residents evacuated.

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

1. Administrator reviewed fire drill record process with Maintenance Director immediately following survey 5/13/26.
2. Administrator reviewed prior fire drills to ensure we are recording the number of residents in the home and the number of residents that were evacuated on or before 6/30/26.
3. Administrator educated Maintenance Director regarding this regulation and the importance of recording only the residents present for the fire drill on or before 7/10/2026.
4. Administrator and Maintenance director will create an audit to ensure any fire drills conducted have the correct number of residents and that all residents are evacuated. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

171b5 - First Aid Kit

17. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

171b5 - First Aid Kit *(continued)*

Description of Violation

The first aid kit in the bus used to transport residents does not include a thermometer. And the antiseptic had an expiration date of 09/25/25.

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

1. Administrator replaced first aid kit which included a thermometer and antiseptic on bus immediately following survey on 5/13/26.
2. Administrator checked throughout facility to ensure first aid kits were complete without expired items on or before 6/30/2026.
3. Administrator educated Maintenance Director regarding this regulation and the importance of always having a complete first aid kit on the bus on or before 7/10/2026.
4. Administrator or designee will create an audit to ensure first aid kit remains complete on the bus. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

183d - Prescription Current

18. 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 05/11/26, Furosemide 20 mg tab, prescribed for resident #7, was in the home's medication cart; however, the medication was discontinued on 05/05/26.

On 05/11/26, Advanced Eye Relief, prescribed for resident #7, was in the home's medication cart; however, this medication was not listed on resident #7's medication administration record.

Repeated Violation - 05/07/2025, et al.

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

1. Clinical Director ensured Resident 7's Furosemide 20mg was removed from the cart. Resident 7 now has an order for eye drops. Both were completed immediately following survey 5/13/26.
2. Clinical Director reviewed residents that were admitted in the last 90 days to verify medications in the cart match physician orders on or before 6/30/2026.
3. Clinical Director or designee educated nursing staff regarding this regulation and the importance of having a physician order for EVERY medication prescribed on or before 7/10/2026.
4. Clinical Director or designee will complete an audit of incoming new residents to ensure a physician's order is present for medications. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

183d - Prescription Current *(continued)*

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

184a - Resident's Meds Labeled

19. 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 Insulin Lispro Inje 100/ml states to inject as per sliding scale: 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, and 401-450=12 units subcutaneously four times daily. This order does not match the prescribed dosage and instructions for administration on the medication administration record. Per the medication administration record, medication is to be administered before meals per a sliding scale that does not match the label.

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

1. Clinical Director reviewed Resident 7's Lispro to ensure the order matched the medication administration record and label immediately after survey 5/13/26.
2. Clinical Director reviewed insulin Lispro orders for residents that were admitted in the last 90 days to ensure the order, label, MAR match on or before 6/30/2026.
3. Clinical Director educated nursing staff regarding this regulation and the importance of insulin medication labels matching the medication administration record and order on or before 7/10/2026.
4. Clinical Director or designee will complete an audit of incoming new residents to ensure insulin medication labels match the medication administration record and order. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #1 is prescribed Loperamide HCL Oral tablet, give one tablet by mouth as needed. On 05/12/26 this medication(s) was not available in the home.

Resident #8's glucometer was not calibrated to the correct time. The glucometer read 10:02 am at 11:04 am. Resident #8 has a doctor's order for a blood sugar checks before meals. On 5/2/2026, the glucometer displayed 132; however 135 was recorded.

Resident #8 is prescribed Lorazepam Oral tablet 0.5 mg, give one tablet by mouth as needed. On 05/12/26 this medication(s) was not available in the home.

Resident #9 is prescribed Glutose 15 oral gel 40%, give 15 grams by mouth as needed for when blood glucose is less than 60 as needed. On 05/12/26 this medication(s) was not available in the home.

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

1. Clinical Director reviewed medications for Residents 1, 8, & 9 to ensure all PRN medications were present and accounted for. Clinical Director calibrated Resident's 8 glucometer to display correct time immediately following survey 5/13/26
2. Clinical Director reviewed residents that were admitted in the last 90 days to verify PRN medications were present and accounted for and glucometers were calibrated correctly on or before 6/30/2026.
3. Clinical Director educated nursing staff regarding this regulation and the importance of having residents' PRN medications present and accounted for and glucometers calibrated correctly on or before 7/10/2026.
4. Clinical Director or designee will complete an audit of incoming new residents to ensure PRN medications are present and accounted for and glucometers are calibrated correctly. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

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 #1 is prescribed Encourage Increase PO fluid intake. Resident #1's 05/2026 medication administration record does not include the initials of the staff person who administered PO fluid intake on 05/07/26 at 2:00 am, 4:00 am, and 6:00 am.

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

1. Clinical Director verified that the PO fluid intake is being encouraged and documented appropriately immediately following the survey 5/13/26.

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

2. Clinical Director reviewed residents with orders for increased PO fluid intake to ensure they are being encouraged and documented correctly on or before 6/30/2026.
3. Clinical Director educated nursing staff regarding this regulation and the importance of following physician orders and documenting correctly on or before 7/10/2026.
4. Clinical Director or designee will complete an audit of incoming new residents to ensure orders are being followed and documented correctly. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

187d - Follow Prescriber's Orders

22. Requirements

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

Description of Violation

Resident #7 is prescribed Furosemide oral tablet 40 mg, take 1 tablet by mouth one time a day at 9:00 am. However, resident #7 was administered Furosemide 40 mg on 05/12/26 at 10:16 am.

Resident #7 is prescribed Latanoprost Ophthalmic Solution 0.0005%, instill one drop in both eyes one time a day at 9:00 am. However, resident #7 was administered Furosemide 40mg on 05/12/26 at 10:16 am.

Resident #7 is prescribed Humalog Kwik Pen Subcutaneous Pen-Injector 100 units/ml; inject as per sliding scale subcutaneously before meals at 8:00 am, 11:00 am, and 4:30 pm. However, on 5/12/26 resident #7 was administered Humalog at 10:26 am and 12:39 pm.

Resident #8 is prescribed Lantus Solostar Subcutaneous Pen-Injector 100 units/ml; inject 15 units at 4:30 pm. However, resident #8 was administered Lantus Solostar on 05/07/26 at 6:05 pm and on 05/08/26 at 5:47 pm.

Resident #9 is prescribed Cyanocobalamin oral tab 500 mcg, take 1 tablet by mouth one time a day at 8:00 am. However, resident #9 was administered Cyanocobalamin 500 mcg on 05/11/26 at 10:56 am and on 05/12/26 at 9:59 am.

Resident #9 is prescribed Famotidine Oral Tab 20 mg, give 1 tablet by mouth twice daily day at 8:00 am and 4:00 pm. However, resident #9 was administered Famotidine 20 mg on 05/11/26 at 10:56 am, on 05/11/26 at 5:16 pm and on 05/12/26 at 9:59 am.

Resident #9 is prescribed Glipizide Oral Tab 10 mg, give 1 tablet by mouth two times a day at 8:00 am and 8:00 pm. However, resident #9 was administered Glipizide 10 mg on 05/11/26 at 10:56 am and on 05/12/26 at 9:59 am.

Resident #9 is prescribed Vitamin D3 Oral Tab 50 mcg, give 1 tablet by mouth one time a day at 8:00. However, resident #9 was administered Vitamin D3 on 05/11/26 at 10:56 am and on 05/12/26 at 9:59 am.

187d - Follow Prescriber's Orders (continued)

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

1. Clinical Director reviewed medications for Resident 7, 8, & 9 to ensure medications were administered and documented in the correct time frame immediately following the survey 5/13/26.
2. Clinical Director reviewed residents that were admitted in the last 90 days to verify medications were being administered and documented in the correct time frame on or before 6/30/2026.
3. Clinical Director educated nursing staff regarding this regulation and the importance of administering and documenting medication in the correct time frame on or before 7/10/2026.
4. Clinical Director or designee will complete an audit of incoming new residents to ensure medications are being administered and recorded in the correct time frame. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)

190a - Completion Medication Course

23. Requirements

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

Description of Violation

Staff person H, has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:

On 04/28/26, at approximately 9:00 am, staff person H administered Aripiprazole oral tablet 5 mg, Atorvastatin Calcium oral tablet 10 mg, Citalopram Hydrobromide oral tablet 10 mg, furosemide oral tablet 20 mg, and Famotidine oral tablet 20 mg, Baclofen oral tablet 5 mg, Alprazolam oral tablet 0.25 mg, and Gaborone oral tablet 100 mg to resident #7.

On 04/01/26, 04/08/26, and 04/28/26 at 9:00 am, staff person H administered Ammonium lactate external lotion 12%, Furosemide oral tab 40 mg, Gabapentin oral capsule 100 mg, Hyoscyamine sulfate oral tablet 0.125 mg, Omeprazole oral capsule delayed release 20 mg, and Polyethylene glycol 3350 powder to resident #10.

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

1. Administrator reviewed staff person H medication administration course status. Administrator informed staff member [redacted] would not be put back on the schedule until [redacted] completed the medication administration course and

190a - Completion Medication Course (continued)

had observations complete, this was done immediately following survey on 5/12/26.
2. Administrator and Clinical Director reviewed our current medication technician staff to ensure all credentials were complete and current on or before 6/30/26.
3. Clinical Director and Med Tech Trainer have been educated regarding this regulation and the importance of ensuring all staff have proper and current credentials on or before 7/10/2026.
4. Administrator or designee will complete an audit of medication technicians to ensure all credentials remain current. This audit will be conducted once a week for a month. The audit results will be reviewed at the facility QAPI meeting on or before 7/10/26.

Licensee's Proposed Overall Completion Date: *07/13/2026*

Implemented ([redacted] - 07/13/2026)