

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

September 17, 2026

[REDACTED], REGIONAL
SNH PENN TENANT LLC
[REDACTED]
C/O INTEGRACARE CORP
[REDACTED]

RE: GLEN MILLS SENIOR LIVING
242 BALTIMORE PIKE
GLEN MILLS, PA, 19342
LICENSE/COC#: 14511

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: GLEN MILLS SENIOR LIVING

License #: 14511

License Expiration: 06/26/2026

Address: 242 BALTIMORE PIKE, GLEN MILLS, PA 19342

County: DELAWARE

Region: SOUTHEAST

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: SNH PENN TENANT LLC

Address: [REDACTED] C/O INTEGRACARE CORP, [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-2

Date: 03/19/2010

Issued By: Concord Township

Type: I-1

Date: 07/20/2023

Issued By: Concord Township

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 86

Waking Staff: 65

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: 100

Residents Served: 63

Secured Dementia Care Unit

In Home: Yes

Area: Life Stories

Capacity: 22

Residents Served: 17

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 63

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 23

Have Physical Disability: 1

Inspections / Reviews

05/11/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 06/11/2026

Inspections / Reviews (*continued*)

06/23/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/10/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 06/28/2026

06/29/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/10/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 07/14/2026

09/17/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/10/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c - Written Incident Report

1. 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 3/17/2026 at 12:12 PM, the fire alarm was set off by an onsite third-party contractor. The local fire department arrived at the home. The home did not report this incident to the Department.

Plan of Correction

Accept () - 06/23/2026)

Immediate action: On 05/11/2026 the Executive Director sent Reportable incident form to DHS via email. Report was not originally submitted due to 2600 Regulation stating false alarms do not require reporting. Contractor failed to cover smoke detector which was triggered by dust during sanding. Fire department responded to alarm however did not enter building.

Staff Training. The Incident Reporting Policy will be reinforced to all staff with a focus on the necessity of reporting any and all incidents, regardless of the cause, within 24 hours. Retrain all staff involved in incident management on the updated procedures and remind them of the importance of prompt and accurate reporting 5/29/2026.

Long term Action: Effective 05/31/2026 the Executive Director or Designee will perform weekly audit of reportable, through 8/31/2026 to maintain ongoing compliance with reporting an 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, and to follow the guidelines in § 2600.15. Executive Director will keep a log of all reportable incidents, as well as confirmation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented () - 08/12/2026)

17 - Record Confidentiality

2. 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 5/11/2026, at approximately 10:40 AM, resident records including lab work and skin assessments were unlocked, unattended, and accessible in the first-floor wellness office.

Plan of Correction

Accept () - 06/29/2026)

Immediate Action Plan: Ensure immediate security and confidentiality of resident records. Wellness door was manually locked and latched and resident records were secured.

Action Plan: Educate staff on the importance of maintaining confidentiality and proper handling of resident records

17 Record Confidentiality (continued)

through in service. The Wellness Office door lock was replaced on 06/01/2026 with a key less entry keypad without a manual unlock option to ensure wellness door remains locked at all times as outlined in 2600 regulations.

Ongoing Plan: Wellness Director or designee will perform weekly audit starting 06/01/2026 for 90 day of wellness door to ensure it is locked and closed when staff are not present in wellness office.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 09/17/2026)

25b - Contract Signatures**3. Requirements**

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident home contract, dated (), for resident 1 was not signed by the resident. There was no indication the resident was given the opportunity to sign.

Repeated Violation 7/29/2025 et al.

Plan of Correction

Accept () - 06/29/2026)

Immediate Action Plan: Contract for resident 1 signed by resident and responsible party on 05 12 2026. Administrative Services Director completed audit of all resident home contracts to ensure they are properly signed by resident and responsible party on 6/1/2026.

Staff Training On Contract Compliance: On 5/28/2026 Administrative Services Director and Community Relations Director educated on resident and responsible party (if applicable) signature on all contracts for adherence to contract signing requirements.

Long term Action: Starting 06/01/2026 Administrative Services Director will perform weekly audits to new admission contracts for 90 days to ensure completion of resident and responsible party signatures. ASD will review audit of new admission and contract signing completion at the monthly QI meeting.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 08/12/2026)

26a - Quality Management Plan**4. Requirements**

2600.

26.a. The home shall establish and implement a quality management plan.

26a - Quality Management Plan (continued)

Description of Violation

The home's quality management plan indicates that staff will meet at least monthly. In 2/2026 a meeting was not held.

Plan of Correction

Accept () - 06/23/2026)

Immediate action: The Safety and Quality Indicators Review Team Meeting (SQIRT) was completed on 5-14-2026. A schedule of the monthly SQIRT meetings was created for the remainder of the year to ensure compliance with 26a regulation.

Staff Training: Review of monthly SQIRT committee expectations and policies held by Executive Operations Officer with Safety & Maintenance Engineer completed on 6/10/2026.

Long Term Action:: Executive Operations Officer or Safety & Maintenance Engineer will conduct Monthly audit for 90 days to ensure SQIRT meeting is held and properly documented.

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented () - 08/12/2026)

26b - Quality Management Plan Content

5. Requirements

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

Description of Violation

The home's quality management reviews dated 3/29/2026 and 4/23/2026 did not address resident or family councils.

Plan of Correction

Accept () - 06/23/2026)

Immediate action: Addition of Resident Council minutes to Monthly SQIRT meeting completed 5-14-2026.

Staff Training: Executive Operations Officer held in-service on completion of SQIRT/Safety Committee meeting forms for Safety & Maintenance Engineer and Life Stages Director to ensure Resident Council minutes are included in the monthly SQIRT meeting.

Proposed plan: EOO or designee will conduct Monthly audit and document audits for 90 days to ensure Resident Council minutes are reviewed at monthly SQIRT meeting.

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented () - 08/12/2026)

65e - 12 Hours Annual Training

6. 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 person B received only 7 hours of annual training in training year 1/1/2025-12/31/2025.

Repeated violation - 4/15/2025 et al.

Plan of Correction

Accept () - 06/23/2026)

Immediate Action: Ensure Staff person B completes training for current year. Staff Member B has completed all scheduled training up to date and is on target to complete annual training as scheduled by 8/31/26. An audit of all employee records conducted on 6/1/26 for annual training hours was completed by Administrative Services Director. Reminders sent to all staff with remaining training modules for current year to complete training by October 31st 2026.

Staff Training: Employee in-service reviewing the importance of their role in attending planned in-services and trainings to meet regulatory standards completed on 5/29/2026. New caregiver training platform for 2026 includes all required hours in training, including 6 extra hours for dementia.

Long term action: Comprehensive annual training plan in place to prevent future non-compliance. Administrative Services Director will monitor and evaluate all staff training programs to ensure completion of scheduled training modules for the next 90 days.

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented () - 08/12/2026)

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.

65g - Annual Training Content (continued)

Description of Violation

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

Repeated Violation - 4/15/2025 et al.

Plan of Correction

Accept () - 06/23/2026

Immediate Action: ASD conducted audit of employee files to ensure employees have annual training, all current employees will attend fire safety training for compliance by 8/31/2026. Training will be offered every two weeks to ensure availability for current staff members. Staff person B completed fire safety training on 6/11/26.

Staff Training: In-service held 5/29/2026 to remind staff of the importance of their attendance for annual trainings including the fire safety training.

Proposed correction: Employee Fire training log put into place to track training needs. Administrative Services Director will audit log monthly for 90 days. All new employees receive fire safety training during initial orientation.

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented () - 08/12/2026

81b - Resident Personal Equipment

8. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 5/11/2026 resident 3's bed had a Halo-brand bedside mobility device attached loosely to the bed frame. The device swung about 6 inches in each direction as well as diagonally on the axis. The device was covered with a loose white pillowcase. A pillowcase does not allow for the safe gripping and use of the device and further presents a risk to the resident.

Plan of Correction

Accept () - 06/29/2026

Immediate Action: Halo Enabler was secured to bed frame on 5/12/2026 per manufacturers instructions and pillow case was removed.

Staff Training: On 5/29/2026 all staff educated on the incident and reinforcement of the importance of checking mobility devices regularly and reporting loose/unsecure enablers to maintenance via work order in Tels system at the front desk.

Proposed correction: Safety & Maintenance Engineer or designee to perform weekly audits for 90 days beginning 06/01/2026 to ensure all resident equipment is maintained in good working order and free from hazards and secured according to manufacturers recommendations, and the resume Monthly audits in Tels system for ongoing

81b - Resident Personal Equipment (continued)

monitoring. SME will attach/secure all enablers on admission to ensure safety and security of device.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 09/17/2026)

82b - Poisonous Material Storage**9. Requirements**

2600.

82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

A bottle of Febreze Professional Sanitizing Fabric Refresher with manufacturer's label indicating "IF ON SKIN: rinse well with water. Call poison control center or doctor for treatment advice", was stored in the memory care kitchen cabinet below the oven next to a large bottle of canola oil.

Plan of Correction

Accept () - 06/29/2026)

Immediate Action: Febreze bottle removed from cabinet and placed in secured cabinet. Thorough inspection of MC area for any other poisonous materials completed by Memory Care Director on 5/11/2026. All poisonous materials located in secured cabinet.

Staff Education: All Staff in-service of identification of and securing poisonous materials completed on 5/29/2026.

Long term Action: Secured Cabinets labeled for material storage. Memory Care Director will conduct weekly audits of memory care resident areas beginning 06/01/2026 to ensure all poisonous materials are being stored in secure cabinets/closets for 90 days.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 08/12/2026)

82c - Locking Poisonous Materials**10. Requirements**

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 5/11/2026, a bottle of Febreze Professional Sanitizing Fabric Refresher, with a manufacture's label indicating "IF ON SKIN: rinse well with water. Call poison control center or doctor for treatment advice", was unlocked, unattended, and accessible to residents the memory care kitchen cabinet below the oven. The door to the kitchen was propped open. Not all the residents of the home, including resident 1, have been assessed as capable of recognizing and using poisons safely.

Repeated Violation - 9/3/2025 et al, 4/15/2025 et al.

82c - Locking Poisonous Materials (continued)**Plan of Correction****Accept () - 06/29/2026)**

Immediate Action: Febreze bottle removed from cabinet and placed in secured cabinet, thorough inspection of MC area for any other poisonous materials completed by Memory Care Director on 5/11/2026. All poisonous materials located in secured cabinet.

Staff Education: All Staff in-service of identification of and securing poisonous materials completed on 5/29/2026.

Long term Action: Secured Cabinets labeled for material storage. Memory Care Director will conduct weekly audits of memory care resident areas to ensure all poisonous materials are being stored in secure cabinets/closets for 90 days beginning 06/01/2026

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 08/12/2026)**85a - Sanitary Conditions****11. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/11/2026 there was pink sherbet spilled and hardened inside the memory care freezer, as well as a long black hair stuck in a yellow grime on the inside lip of the memory care freezer.

In resident 4's private bathroom there was a used wet brief on the floor.

Plan of Correction**Accept () - 06/29/2026)**

Immediate Action: Housekeeping conducted an inspection and cleaning of the memory care freezer removing all soilage, dust and dirt. Resident 4's private bathroom was cleaned and soiled brief was bagged and disposed of. Resident wellness director met with resident on 5/12/2026 to review proper disposal of soiled products and will review residents' ability for self-care for the next 30 days to determine if a change in level of care is necessary.

Staff Education: Education provided to all staff to reinforce the importance of maintaining sanitary conditions and proper cleaning protocols, including guidance on addressing spills promptly completed on 5/29/2026.

Proposed correction: In-service for housekeeping department regarding cleaning the food storage areas and resident bathrooms, followed by weekly audits of SDU refrigerator for 90 days beginning 06/01/2026 to ensure cleanliness by director of SDU or designee.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 09/17/2026)**96b - First Aid Location****12. Requirements**

2600.

96b - First Aid Location (continued)

96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

Staff persons C, D, E, and F, did not know the location of the first aid kit.

Plan of Correction

Accept () - 06/29/2026)

Immediate Action: First aid kit location sign hung outside wellness center for ease of location identification. On 5/29/2026, an electronic message sent to all staff as to location of Kits.

Staff education: All employees educated as to the location of first aid kits in Wellness Office through Inservice completed on 5/29/2026.

Proposed correction: Location of first aid kits has been added to the fire & safety training for all new employees during orientation by the Safety & Maintenance Director. Location of the first aid kits will be reviewed at monthly safety committee meeting for the next 90 days by Safety & Maintenance Engineer or designee beginning 06/01/2026

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 08/12/2026)

101j5 - Bedside Table/Shelf**13. Requirements**

2600.

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

5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident 5's bed.

Plan of Correction

Accept () - 06/29/2026)

Immediate action: Resident shares room () on admission two twin beds were separated and bedside table and lamp was located in between beds within reach of both residents. Post admission resident moved beds together and placed table/lamp on one side of bed. Resident refused placement of table at bedside. Resident notified of regulation surrounding required furniture in residence and agreed to a shelf being installed at bedside. Shelf was installed on 5/14/2026.

Staff Education: On 5/29/2026, Staff educated on compliance requirements regarding bedroom furnishings and reporting deficiencies to maintenance for repair/replacement via work orders in Tels system at the front desk.

Proposed plan: Safety & Maintenance Engineer to conduct weekly audit for 90 days for bedside table/shelf placement in occupied resident apartments beginning 06/01/2026.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 09/17/2026)

101j7 - Lighting/Operable Lamp**14. Requirements**

101j7 Lighting/Operable Lamp (continued)

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 5 does not have access to a source of light that can be turned on/off at bedside.**Repeated Violation - 7/29/2025 et al; 4/15/2025 et al.***Plan of Correction****Accept () - 06/29/2026)***Immediate action: Resident shares room () on admission two twin beds were separated and bedside table and lamp were located in between beds within reach of both residents. Post admission resident moved beds together and placed table/lamp on one side of bed. Resident refused placement of table at bedside. Resident notified of regulation surrounding required furniture in residence and agreed to a push light being installed at bedside. Light was installed on 5/29/2026.**Staff Education: On 5/29/2026, Staff educated on compliance requirements regarding bedroom furnishings and reporting deficiencies to maintenance for repair/replacement via work orders in the Tels system at the front desk.**Proposed plan: Safety & Maintenance Engineer to conduct weekly audit for 90 days of bedside lamp placement in occupied resident apartments beginning 06/01/2026.***Licensee's Proposed Overall Completion Date: 06/24/2026****Implemented () - 08/12/2026)****103c Food Protected****15. Requirements**

2600.

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

Description of Violation*On 5/11/2026 there were multiple uncovered containers of ice cream stored in the ice freezer.***Plan of Correction****Accept () - 06/29/2026)***Immediate Action: Ice cream containers were covered and sealed for protection. Cardboard lids were only present day of survey due to ice cream being delivered that morning. Plastic lids put in place for ice cream containers following lunch meal. All containers have plastic lids in place.**Staff Education: On 5/29/26 all staff were in serviced on the importance of proper and safe food handling and storage procedures to prevent contamination, including securing ice cream lids when not is use.**Proposed correction: Dining Services Director or designee to perform biweekly audit for 90 days to ensure lids are placed on ice cream in wagon freezer beginning 05/13/2026.*

103c Food Protected (continued)

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 08/12/2026)

103i - Outdated Food

16. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 5/11/2026 there was an unlabeled, undated dressing cups in the prep refrigerator, a bag of unsealed, undated meatballs in the walk in freezer, and an unlabeled container of hot mustard in the walk in refrigerator.

Plan of Correction

Accept () - 06/29/2026)

Immediate action: Food that was not labeled or dated was discarded. on 5/11/2026 Inspection of Prep refrigerator, walk in freezer, and reach in refrigerator was completed and all food without dates/labels were discarded.

Staff Education: On 05/29/2026, all staff Inservice held to review food safety procedures and proper dating/labeling of all food in all refrigerators and freezers was completed.

Proposed Correction: Dining service director or designee will perform biweekly audits to cold/dry food storage and ensure all items are sealed or labeled with contents and open/prop date for 90 days beginning 05/13/2026.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 08/12/2026)

132a - Monthly Fire Drill

17. 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 12/2025 and 2/2026.

Plan of Correction

Accept () - 06/23/2026)

Immediate Action: Review of the fire drill log completed 5/13/2026, and Two fire drills were completed in January (1st & 30th). which establishes an average of five fire drills in five months.

Staff Education: On, 6/2/2026, Executive Operations Officer met with the new Safety & maintenance Engineer to review policy and procedure for completing fire drills monthly.

Proposed correction: A schedule for fire drills completed for 2026 to include overnight drills. ED and Maintenance Director have monthly reminders set for fire drills in Tels system for monitoring. Executive Operations Officer or designee to audit fire drills for 90 days to ensure completion.

132a - Monthly Fire Drill (*continued*)

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

Implemented () - 08/12/2026

132c - Fire Drill Records

18. Requirements

2600.

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 drills conducted on 4/30/2026 at 10:26, 1/30/2026 at 10:17, 10/14/2025 at 10:38, 8/29/25 (written as 24) at 9:16, 7/22/25 at 3:17 and 6/24/25 at 11:49 do not include an indicator of AM or PM.

The fire drill record for the drills conducted on 4/30/2026, 11/26/2025 at 5:55 PM, 10/14/2025, and 9/30/2025 at 5:09 PM do not include the exit route used.

Plan of Correction

Accept () - 06/23/2026

Immediate correction: Executive Operations Officer reviewed fire drill reports for completion and consistency of time units, exit routes.

Staff Education: Safety & Maintenance Engineer Educated to fire drill policy and using consistent terminology on 6/2/2026.

Proposed correction: Executive Operations Officer or designee will review documentation for each fire drill for 90 days to ensure times are accurate and times are consistently labeled AM/PM, and exit routes are alternating.

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented () - 08/12/2026

132e - Fire Drill Sleeping Hours

19. Requirements

2600.

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

Description of Violation

The last fire drill conducted during sleeping hours was on 1/1/2026 at 5:20 AM. The home did not provide documentation of a previous sleeping hours fire drill.

Plan of Correction

Accept () - 06/23/2026

Immediate Action: An overnight fire drill was completed on 5/26/26 to maintain compliance with overnight drill every six months. Documentation of fire drill is completed and filed.

Staff Education: Executive Operations Officer reviewed fire drill policies and procedures with Safety & Maintenance

132e - Fire Drill Sleeping Hours (continued)

Engineer on 6/02/2026 to include rotating times/locations/frequency.

Proposed correction: A schedule for fire drills completed for 2026 to include overnight drills in Tels system for auto-prompting. Next overnight drill scheduled prior to 11/26/26. Executive Operations Officer or designee to audit fire drills for 90 days to ensure policy is being followed and include overnight drill frequency.

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

Implemented () - 08/12/2026

132h - Designated Meeting Place**20. Requirements**

2600.

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

Description of Violation

During the fire drill on 3/17/2026 at 12:12 PM, residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. Documentation shows that during the fire drill there were 55 residents in home and only 6 residents evacuated.

During the fire drill on 1/30/2026 at 10:17 (no AM or PM indicated), residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. Documentation shows that during the fire drill there were 54 residents in home and only 10 residents evacuated.

Plan of Correction

Accept () - 06/23/2026

Immediate correction: Fire drill conducted on 1/30/26 and 3/17/26 were reviewed and found to have documentation errors in reported residents in home vs. residents evacuated. During both drills, all residents in the home were successfully evaluated.

Staff Education: Executive Operations Officer & Safety & Maintenance Engineer reviewed Fire Safety Regulations as well as Policy & procedures manual related to completion of fire drill reports on 6/2/2026 to include all residents evacuated vs. residents evacuated from simulated fire area only.

Proposed correction: Executive Operations Officer or designee will review documentation for fire drills Monthly for 90 days to ensure accuracy.

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented () - 08/12/2026

162c - Menus Posted**21. Requirements**

2600.

162c Menus Posted (continued)

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 5/11/2026 in the memory care area of the home the menu was posted for 3/1/2026 4/4/2026

Plan of Correction

Accept () - 06/23/2026)

Immediate Action: 4 week menu was replaced with current menus in all posted areas.

Staff Education: Memory Care director and Dining service director educated as to policy regarding 4 week trailing menu posting on 5/12/2026.

Proposed correction: Memory Care Director or designee will complete weekly audit of menu posting for 90 days to ensure compliance with menu posting.

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented () - 08/12/2026)

181d -Storing Medication**22. Requirements**

2600.

181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident 6 self administers medications and stores medications in [REDACTED] room. On 5/12/2026 at 11:03 PM, there were several unlocked, unattended medications to include Tylenol Extra Strength, CVS Cold and Flu both daytime and nighttime. Magnesium 250 mg, Extra Strength Gas Relief and Tamsulosin 0.4mg in an unlocked black box in the resident's bedroom which [REDACTED] shares with [REDACTED] who is not capable of self administering medications.

Plan of Correction

Accept () - 06/29/2026)

Immediate Action: Medication storage was secured immediately. Resident Wellness Director conducted immediate audit of resident medications against physician orders to ensure all medications in resident lock box had corresponding physician orders.

Staff Education: On 5/29/2026, Staff inservice held to review resident self medicating policy, staff to immediately close/lock medication boxes if found unlocked and report to wellness director for follow up. Resident educated to policy regarding each medication having a corresponding physicians order.

Proposed correction: Resident Wellness Director or designee will conduct Weekly audits of self medicating resident lock boxes to ensure proper security of medications for 90 days beginning 06/01/2026 and then resume completion of quarterly self medication assessments per policy.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 09/17/2026)

181f Record of Medication**23. Requirements**

2600.

181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self administering his medication.

Description of Violation

On 5/12/2026, resident 6's record did not include a current list of medications. The list in the resident's record did not include Tylenol Extra Strength, CVS Cold and Flu both daytime and nighttime, Magnesium 250 mg, Extra Strength Gas Relief and Tamsulosin 0.4 mg.

Resident 7's current list of medication included Acetaminophen tab 500 mg and Docusate 100 mg capsule however the resident did not have these medications in [REDACTED] possession and stated [REDACTED] does not take them.

Plan of Correction**Accept ([REDACTED] - 06/23/2026)**

Immediate action: Medications for resident 6 without corresponding physicians orders were removed from resident room on 5/12/2026. Medications for resident 7 were in resident wellness director office and were placed back in resident lock box on 5/12/2026.

Staff Education: Staff in-service completed 5/29/2026 to review medication policies, and any medications not included on physician's orders to be removed from resident lock boxes and given to resident wellness director to determine necessity of medication and obtain physician's order if applicable.

Proposed plan: RWD or designee will audit self-medicating resident medication boxes weekly for 90 days to ensure all medications have a corresponding physician order and then resume quarterly self-medicating assessments per policy.

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented ([REDACTED] - 09/17/2026)**183b Meds and Syringes Locked****24. Requirements**

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 5/12/2026 at 11:03 PM, a bottle of resident 5's Bupropion HCL 200 mg tablets was unlocked, unattended, and accessible in [REDACTED] bedroom. Resident 5 has not be assessed as capable of self- administering medications.

Plan of Correction**Accept ([REDACTED] - 06/29/2026)**

Immediate Action: Resident 5 shares living space [REDACTED] (resident 6) who is a self-medicator. Resident 6 picked up medication from outside pharmacy and left medication unsecured in [REDACTED] medication box. Medication was removed from resident room and disposed of per policy on 5/11/26 as residents no longer had active order for this dosage.

Staff education: Staff in-service completed 5/29/2026, including reporting medication found in resident rooms who are not self-medicating to Resident Wellness Director for follow up. Wellness Director also reviewed policies with

183b - Meds and Syringes Locked (continued)

resident 6 for compliance with proper handling of medications (resident 5) who is not self-medicating.

Proposed correction: RWD or designee will conduct Weekly audits for 90 days beginning 06/01/2026 of resident 6 medication box to ensure all medications are prescribed to resident 6, and no medications belonging to resident 5 are present in resident apartment.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 09/17/2026

183e - Storing Medications**25. Requirements**

2600.

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

Description of Violation

On 5/11/2026 the following blister packs were observed with punctures in the foil or paper backing of the blister packaging:

Resident 8's Carb/Levo tab 25-100 mcg noon package was punctured at spot 1, and afternoon package was punctured at spot 7, the medication was still present in both spots.

Resident 9's ezetimibe tab 10 mg was punctured at spot 5, with the medication still in the spot.

Repeated Violation - 9/3/2025 et al.

Plan of Correction

Accept () - 06/29/2026

Immediate action: Identified damaged blister medications for residents 8 & 9 were disposed of on 5/11/26 per policy. On 5/18/2026 Resident Wellness director and designee completed full medication cart inspection on three carts to determine if any other medication cards had damaged blisters. Any medication blisters found with damage were emptied and discarded per policy.

Staff Education: on 5/29/26 in-service held for medication administration staff including using caution while moving blister packs to reduce damages and discarding of any medications in which the blister pack had been compromised.

Proposed correction: RWD or designee will conduct Med Cart audits for broken blister packs weekly for 90 days beginning 06/01/2026. Larger medication cart arrived to facility on 6/3/26 to ensure space for safe storage of medications and reduce potential for damage.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 09/17/2026

185a - Implement Storage Procedures**26. Requirements**

2600.

185a - Implement Storage Procedures (continued)

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

Resident 8 is prescribed Loperamide 2 mg- take one capsule by mouth after each loose bowel movement as needed. On 5/11/2026 this medication was not available in the home.

Resident 9 is prescribed Accu-Chek's twice daily at 9:00 AM and 9:00 PM.

On 5/2/2026 at 10:00 PM a reading of 226 is recorded in the residents glucometer but it is not documented on the residents May 2025 Medication Administration Record (MAR).

On 5/3/2026 at 9:43 AM a reading of 155 is recorded in the residents glucometer but it is not documented on the MAR.

Resident 10 is prescribed Fluticasone spray 50 mcg- use one spray in each nostril daily as needed. On 5/11/2026 this medication was not available in the home.

Plan of Correction**Accept () - 06/29/2026)**

Immediate action: Resident 8 PRN medications not in stock were re-ordered on 5/11/26 and have been placed in medication cart for availability. Resident 10 Fluticasone refilled on 5/12/26 and in cart for availability. Resident wellness director reviewed resident 9 record and staff on duty report resident was symptomatic prompting PRN accucheck, which was not documented in MAR.

Staff Education: On 5/29/2026, staff was educated that all glucometer readings and medication administrations are documented accurately and timely in the MAR, and that all PRN medications are present and available for administration.

Proposed Correction: An initial audit of PRN medications completed, and weekly PRN audit initiated for 90 days beginning 06/01/2026 to be completed by Resident Wellness Director or designee. Resident Wellness Director or designee will complete Glucometer and MAR documentation audits weekly for 90 days to ensure proper documentation.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 09/17/2026)**187d - Follow Prescriber's Orders****27. Requirements**

2600.

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

Description of Violation

Resident 8 is prescribed to have blood pressure readings to be taken daily both sitting and standing at 2:00 PM, however, these readings were not taken 4/21/2026, 4/23/2026, 4/24/2026, and 5/5/2026.

Resident 11 is prescribed Meclizine 25 mg at 9:00 AM, however, this medication was not administered until 10:15 AM on 5/11/2026.

187d - Follow Prescriber's Orders (continued)

Repeated Violation - 9/3/2025 et al; 4/15/2025 et al.

Plan of Correction**Accept () - 06/29/2026)**

Immediate Action: PCP notified of missing vital signs for resident 8 and late administration of dose for resident 11. Reportable sent to DHS regarding late administration on 5/11/2026. Resident 11 medication was administered 15 minutes late due to CMT scanning medication and receiving error code on computer, prompting CMT to take medication to Wellness director for verification prior to administration. PCP discontinued vital signs for resident 8.

Staff Training: Education for CMT's on importance of following Physicians orders, obtaining and recording vital signs as ordered, and administering medications in a timely manner.

Proposed correction: Resident Wellness Director or designee to conduct weekly MAR audits for 90 days beginning 06/01/2026 to include any resident on Physician ordered vital signs and review/report any late administration.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 09/17/2026)**225c - Additional Assessment****28. 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 doe not have an accurate assessment of the residents ability to self- administer medications or their ability to safely use or avoid poisonous materials. Resident 1's medical evaluation that was completed on () indicates () cannot self-administer medications and cannot safely use and avoid poisons. Resident 1 resides in the home's secure dementia care unit. Resident 1's most recent assessment, dated () indicates the resident can self-administer medications and can safely use and avoid poisonous materials.

Plan of Correction**Accept () - 06/23/2026)**

Immediate Action: Resident RASP was reviewed and updated on 5/12/26 to reflect current level of care and assistance needed, including medication administration and ability to use and avoid poisonous materials.

Staff Education: Resident Wellness Director re-educated as to the importance of accurate assessments for resident care, medication administration and safety concerns.

Proposed correction: Current resident RASP audit to ensure correct level of care (Completed 5/19/2026). Resident Wellness Director will conduct a review of Support plans for current residents to ensure accuracy of RASPs, to be completed by 6/15/2026. Resident wellness director or designee will audit each residents RASP 30 days after admission for accuracy for the next 90 days.

225c - Additional Assessment (*continued*)

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented () - 08/12/2026)

233c - Key-Locking Devices

29. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the doors to the outside in the Secure Dementia Care Unit (SDCU). Posted codes were incorrect.

Repeated violation - 7/29/2025 et al.

Plan of Correction

Accept () - 06/29/2026)

Immediate Action: On 5/11/26 EOO reset mag lock code box and all were operational, door released properly, code posted at door.

Staff Education: on 5/29/26 staff educated to the proper operation of locking mechanisms for memory care area. Staff to report malfunctions to safety & maintenance engineer for repair or follow up.

Proposed correction: Key pads were reset and are functioning properly. Safety & Maintenance Engineer or designee will do a weekly audit on all Mag log doors in SDU to ensure proper release and posting for 90 days beginning 06/01/2026.

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented () - 09/17/2026)

251b - Record Entries Legible

30. 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

Resident 7's document of medical evaluation dated as [REDACTED] for the in-person evaluation has an illegible date in the form completed: section due to multiple numbers being written over each other. Resident 7's document of medical evaluation with a date indicating the form was completed on [REDACTED] has an illegible date of in-person evaluation and weight because of multiple numbers written over each other.

Plan of Correction

Accept () - 06/29/2026)

Immediate Action: DME audit was performed on 6/2/2026 on all resident forms to ensure documentation is legible and correctly dated.

Staff education: Resident Wellness Director educated on the importance of legible and accurate records, and

251b - Record Entries Legible (continued)

appropriate corrective procedures (initials/dates) for all medical records.

Proposed correction: Resident Wellness Director will audit weekly all new admission, annual, and significant change DME's for accuracy and legibility for 90 days beginning 06/01/2026

Licensee's Proposed Overall Completion Date: 06/24/2026

Implemented ([REDACTED] - 08/12/2026)