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

July 7, 2026

[redacted], DIRECTOR OF OPERATIONS MANAGER
LCS DOYLESTOWN LLC
[redacted]

RE: THE SOLANA DOYLESTOWN
1621 EASTON ROAD
WARRINGTON, PA, 18976
LICENSE/COC#: 14531

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/12/2026, 05/13/2026 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: *THE SOLANA DOYLESTOWN* **License #**: *14531* **License Expiration**: *09/11/2026*

Address: *1621 EASTON ROAD, WARRINGTON, PA 18976*

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

Administrator

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

Legal Entity

Name: *LCS DOYLESTOWN LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-1* **Date**: *09/22/2014* **Issued By**: *CWOPA*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *117* **Waking Staff**: *88*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/13/2026*

Inspection Dates and Department Representative

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

05/13/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *129* **Residents Served**: *80*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care Unit* **Capacity**: *34* **Residents Served**: *27*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *80*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *37* **Have Physical Disability**: *0*

Inspections / Reviews

05/12/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/12/2026*

06/24/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/03/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/02/2026*

Inspections / Reviews *(continued)*

07/07/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/03/2026*

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

81b - Resident Personal Equipment

1. 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 5/12/26, an uncovered bedside mobility device was installed on the bed of resident 1. Per FDA guidelines, the openings within the device should be less than 120 mm (4 ¾ inches). If any openings within the device exceed 120 mm (4 ¾ inches), a cover that allows for safe gripping and use of the device for its intended purpose must be in place. The opening of resident 1's bedside mobility device measured 9 in wide by 7 in high. The bedside mobility device was not securely attached to the bed frame and could be pulled away from the bed, creating a hazardous zone of approximately 10 inches.

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

Immediate Corrective Actions: On 5/14/26 the Resident Care Director (RCD) met with Resident 1 to explain this regulation and make [redacted] aware of the need to remove the uncovered bedside mobility device, as the Resident had it installed by one of [redacted] family members without our knowledge.

Additional Corrective Actions: The RCD sent a letter out on 5/21/26 to family members/responsible parties of our residents, to clarify the use of bedside mobility devices per guidelines provided by the Bureau of Human Services Licensing and our company policy. Family members are reminded of the need to contact us when their loved one, our Resident, is considering the use of any bedside mobility device, to allow us to complete the required assessment and ensure compliance with safety and regulatory guidelines.

Ongoing Quality Assurance Actions: The Executive Director will re-educate all staff by 06/30/26 on bedside mobility devices and the requirement for approval by the leadership team prior to use. The Resident Care Director (RCD), Memory Care Director (MCD), and Maintenance Director will maintain a list of bed mobility devices. Beginning 7/01/26, the Maintenance Director or designee will inspect placement of the bed mobility devices monthly to ensure compliance with regulation 2600.81b. The safety checklist will be updated and maintained by the Maintenance Director. Compliance will be reported quarterly to QI committee. QA Meetings to be held as follows: Q2 on 7/15/26; Q3 on10/21/6 and Q4 on 1/13/27. Any unapproved equipment identified will be removed immediately.

**The RCD, MCD, and Maintenance Director are responsible for oversight of ongoing compliance.*

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

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

82c - Locking Poisonous Materials

2. 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 5/12/26 at 11:00am, a tube of Ultrabrite toothpaste with a manufacturer's label indicating, "If more than what is

82c - Locking Poisonous Materials (continued)

used for brushing is accidentally swallowed, get medical help or contact poison control center right away," was unlocked and unattended and accessible to Resident 2's room. Not all the residents of the home, including Resident 2, have been assessed as capable of recognizing and using poisons safely.

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

Immediate Corrective Actions: On 5/12/26 the Memory Care Director (MCD) entered the apartment of Resident 2 and placed the Ultrabright toothpaste in Resident 2's locked cabinet. The MCD and the Caregivers in this neighborhood conducted checks of each Resident apartment, and all common spaces, to confirm there were no additional unsecured poisonous materials present. Every Resident apartment in this neighborhood has a locked cabinet.

Additional Corrective Actions: On 6/08/26 the MCD sent a letter to the family members/responsible parties of the memory care residents, to clarify the policy regarding toiletries and poisonous materials, specific to this regulation.

Ongoing Quality Assurance Actions: Effective 5/18/26, weekly audits are completed by assigned Med Techs/Caregivers for 60 days. On 7/20/26 we will transition to monthly audits, conducted by the Memory Care Director or a designee. Audit results will be reviewed by the leadership team at the Quality Improvement Meetings, and any repeat concerns will result in corrective action counseling. The 2nd Quarter Quality Meeting is scheduled for 7/15/26. The Executive Director facilitated the monthly all-staff meeting on 5/27/26, and staff in attendance learned about the importance of securing poisonous materials. Any Med Tech and Caregiver that was unable to attend the all-staff meeting, will receive the same information by 6/30/26.

**The Memory Care Director is responsible for oversight of on-going compliance.*

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

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

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

On 5/12/26 at 11:04 am, there were dried feces observed on the shower chair of room 110. There was also a strong odor of urine throughout room 110.

On 5/12/2026, staff member A did not sanitize their hands between medication passes with resident 3 at 1:30 p.m. and resident 4 at 1:39 p.m.

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

** Part1 Violation-On 5/12/26 at 11:04 am, there were dried feces observed on the shower chair of room 110. There was also a strong odor of urine throughout room 110.*

Immediate/Additional Corrective Actions: On 5/12/26, the Memory Care Director (MCD) and the Housekeeper

85a Sanitary Conditions (continued)

assigned to Memory Care went into apartment 110 and cleaned it up immediately. The MCD had staff review the current RASP for the Resident in Apartment 110, as it was recently updated on 4/14/26. MCD asked staff to check on [redacted] apartment before and after breakfast.

Ongoing Quality Assurance Actions: As of 5/13/26 MCD or Med Tech to complete daily check for Resident in apartment 110 for 30 days, and transition to weekly checks as of 6/15/26 to ensure on going compliance.

** Part 2 Violation On 5/12/2026, staff member A did not sanitize their hands between medication passes with resident 3 at 1:30 p.m. and resident 4 at 1:39 p.m.*

Immediate/Additional Corrective Actions: On 5/12/26, the Resident Care Director (RCD) met with staff member A at the end of [redacted] shift to review the circumstances related to the medication passes and re educate [redacted] regarding hand hygiene. On 5/12/26, the RCD completed a Coaching Form with staff member A, which was reviewed and signed, to ensure understanding of best practices.

Ongoing Quality Assurance Actions: RCD sent a Memo to all Med Techs on 5/12/26 outlining best practices related to Hand Hygiene Requirements During a Medication Pass to re educate staff. Best practices will be reviewed at an in service held on 6 24 26 for Med Techs and Nurses.

**The RCD, MCD, and Maintenance Director are responsible for oversight of ongoing compliance.*

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

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

95 - Furniture and Equipment

4. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 5/12/26 at 10:56 am, the oven door in the memory care kitchenette was hanging off its hinges.

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

Immediate Corrective Actions: On 5/13/26, the Memory Care Director secured the drawer in front of the oven in the memory care kitchenette.

Additional Corrective Actions: The door will be removed completely by 6/22/26, as the memory care kitchenette is being updated with new cabinets.

Ongoing Quality Assurance Actions: Staff were reminded that any and all repairs needed must be placed in the TELS Work Order System. A record of all repairs can be reviewed in this system. A memo will be posted for all staff and this best practice will be reviewed in our next staff meeting on 6/24/26.

95 - Furniture and Equipment (continued)

**The Maintenance Director is responsible for oversight of on-going compliance.*

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

Implemented (- 07/07/2026)

101j3 - Bed/Linens/Pillows/Blankets

5. 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

On 5/12/26 at 11:03am, the bed for Resident 5 did not have a fitted sheet and pillowcase.

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

Immediate/Additional Corrective Actions: On 5/12/26, the Memory Care Director (MCD) and the Housekeeper assigned to Memory Care went into Resident 5's (apartment and the bed was made immediately after the apartment was cleaned. The MCD had staff review the current RASP for Resident 5, in Apartment as it was recently updated on 4/14/26. MCD asked staff to check on apartment daily after breakfast to make sure the bed is made.

Ongoing Quality Assurance Actions: As of 5/13/26 MCD or Med Tech to complete daily check for Resident 5 in apartment for 30 days, and transition to weekly checks as of 6/15/26 to ensure on-going compliance.

**The Memory Care Director is responsible for oversight of on-going compliance.*

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

Implemented (- 07/07/2026)

102h - Toilet Paper

6. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 5/12/26, at 10:46am, there was no toilet paper for the toilet in the bathroom in room 314.
On 5/12/26 at 11:03am, there was no toilet paper for the toilet in the bathroom in room 110.

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

Immediate Corrective Actions: Toilet Paper was immediately placed in both Apartments 314 and 110 when it was noted that the Resident's had run out.

Additional Corrective Actions: The Executive Director facilitated the monthly all-staff meeting on 5/27/26 and completed a review of the Licensing Inspection Summary results from our survey. Staff in attendance were reminded of the importance of our roles in meeting the needs of the residents. Toilet paper is provided to our Residents and

102h Toilet Paper (continued)

can be found in the housekeeping closets. Any Med Tech and Caregiver that was unable to attend the all staff meeting, will receive the same information by 6/30/26.

Ongoing Quality Assurance Actions: The Executive Director and Maintenance Director have a meeting scheduled with the Housekeeping Team on 6/16/26. Per the schedule, each Resident apartment is cleaned weekly. Housekeepers utilize the Apartment Cleaning Checklist, and toilet paper is replenished weekly. Housekeepers will be instructed to leave a spare roll of toilet paper in each apartment, and caregivers will be instructed to check on toilet paper supply daily, when checking on Residents in their apartments.

**The RCD, MCD, and Maintenance Director are responsible for oversight of ongoing compliance.*

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

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

103e - Left Overs

7. Requirements

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

Description of Violation

On 5/12/26 at 11:11am, there were unlabeled, undated bags of chicken and ravioli in the main kitchen walk in freezer.

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

Immediate Corrective Actions: On 5/12/26, the Dining Director immediately removed the bag of chicken and the ravioli from the walk in freezer, labeled and dated the items, and stored them properly.

Additional Corrective Actions: The Dining Director held 2 staff meetings: one on 6/10/26 and one on 6/12/26 to review the results of the survey and re educate the Dining Staff regarding best practices and expectations.

Ongoing Quality Assurance Actions: To ensure on going compliance, the Dining Director or the designated cook will monitor dates and labels daily as of 6/16/26, and will continue for 1 month, and then will transition to weekly checks as of 7/20/26.

**The Dining Director is responsible for oversight of ongoing compliance.*

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

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

104b - Dishes/Glassware/Utensils

8. 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.

104b - Dishes/Glassware/Utensils *(continued)*

Description of Violation

On 5/12/26 and 5/13/26, the Department observed Styrofoam take-out containers being used by the dining department to deliver meals to residents in their rooms. When residents do not wish to eat in the dining room, they are brought Styrofoam containers to their individual rooms.

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

Immediate Corrective Actions: Plate covers and additional glassware were ordered, and upon delivery on 6/05/26, we stopped using Styrofoam containers to deliver take-out meals to residents. We are using China plates, silverware, and glassware, and have discontinued use of any Styrofoam containers for residents. Disposable products will only be used for special occasions as stated in this regulation.

Additional Corrective Actions: The Dining Director held 2 staff meetings: one on 6/10/26 and one on 6/12/26 to review the results of the survey and re-educate the Dining Staff regarding best practices and expectations.

Ongoing Quality Assurance Actions: Discontinued use of Styrofoam as of 6/05/25.

**The Dining Director is responsible for the oversight of ongoing compliance.*

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

Implemented (- 07/07/2026)

107d - Procedure Emergency Management Agency Submission

9. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The written emergency procedures have not been reviewed, updated, or submitted annually to the local emergency management agency.

Repeat Violation 2/11/2025 et al

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

Immediate Corrective Actions: Executive Director researched and reviewed previous Licensing Inspection Summary from 2/11/2025, as a transition in ownership and management of the community occurred in September 2025. We were unable to locate a letter to verify the required annual Emergency Management Agency submission referenced in the POC, marked as Accepted on 3/18/25. The POC from 2025 indicates that the submission was expected to be sent to the local emergency management office by 3/15/25, but we have no way to confirm.

Additional Corrective Actions: As the current owner and management company are preparing for a change in licensure, the Executive Director and the Leadership/Support Team are reviewing and finalizing our Emergency Management Submission.

Ongoing Quality Assurance Actions: The Executive Director will be responsible for submitting the plan by 6/30/26 to the Director of Emergency Services for the Warrington Township Department of Emergency Service; which is the local office serving our community.

107d Procedure Emergency Management Agency Submission (continued)

**The Executive Director and the Maintenance Director are responsible for ongoing compliance.*

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

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

132d - Evacuation

10. 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

The home has a maximum safe evacuation time specified in writing within the past year by a fire safety expert of 12 minutes. The home exceeded an evacuation time of 12 minutes during the following drills:

6/26/2025 14 minutes and 53 seconds
9/24/2025 12 minutes and 44 seconds
7/18/2026 14 minutes and 05 seconds

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

Immediate Corrective Actions: The Executive Director reviewed the current contract on 5/21/26 with our Fire Safety vendor. Having come on board as the management company in September of 2025, we signed a new Service Agreement with Fire & Life Safety Solutions on 10/06/2025 to cover facilitating 12 Monthly Fire Drills, Post Fire Drill In service, Electronic Documentation for All Paperwork required for Compliance with the PA. Department of Human Services, and a Fire Safety Inspection and Supervised Fire Drills for Solana Doylestown. The terms of our Service Agreement started on 1/01/2026 and runs through until December 31, 2026.

Additional Corrective Actions: The Executive Director and Maintenance Director reviewed the Fire Drill logs, and we have shown consistent and steady improvement. We have not exceeded our evacuation time since 9/24/25. If any drill would ever exceed the evacuation time, it will be repeated, as part of our service agreement with our Fire Safety vendor.

Ongoing Quality Assurance Actions: Our Maintenance Director continues to conduct hands on Fire Safety Training on Day 1 of New Employee Orientation and includes a detailed tour of the community. The Fire Drill results will be reviewed by the leadership team at the Quality Improvement Meetings. The 2nd Quarter Quality Meeting is scheduled for 7/15/26.

**The Executive Director and the Maintenance Director are responsible for oversight of ongoing compliance.*

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

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

132d Evacuation *(continued)*

141b1 - Annual Medical Evaluation

11. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 2's most recent medical evaluation was completed on [redacted] The resident's previous medical evaluation was completed on [redacted]

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

Immediate Corrective Actions: The Memory Care Director (MCD) acknowledged that the medical evaluation was not completed timely. MCD planned for Resident 2 to be seen by the Physician on 5/26/26. A new DME was completed, and going forward, the Resident's assessment date will be based on this update, unless there is a significant change noted.

Additional Corrective Actions: Our Regional Vice President of Resident Care continues to work with us providing a Monthly Compliance report so we can measure our performance and track our progress.

Ongoing Quality Assurance Actions: The community uses an Electronic Health Record, and we will review all DME expiration dates and add them to the EHR to ensure compliance. We review and update all Residents assessments every 6 months to ensure ongoing compliance. The Memory Care Director (MCD) and Resident Care Director (RCD) are responsible for checking the dashboard to identify the timeline for completing the medical evaluations.

**The MCD and RCD are responsible for oversight of ongoing compliance.*

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

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

162c - Menus Posted

12. Requirements

2600.
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 5/12/26 at 10:03am, the home's menu for the week of 5/10/26 was posted; however, it was not posted for the following week.

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

Immediate Corrective Actions: The Dining Director was scheduled off on Monday and posted the Week 2 Menu at 11:00am. on Tuesday, 5/12/26 after the physical site inspection of the dining room occurred.

Additional Corrective Actions: Going forward, the Week 2 Menu will be posted on Saturdays by the Dining Director

162c - Menus Posted (continued)

or the designated cook.

Ongoing Quality Assurance Actions: The Executive Director will check the Menu Board every Monday, beginning 6/15/26 to ensure menus for 2 weeks continue to be posted.

**The Dining Director and the Executive Director are responsible for the oversight of ongoing compliance.*

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

Implemented (- 07/07/2026)

181f - Record of Medication

13. 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 medication.

Description of Violation

On 5/12/26, Resident 1's record did not include a current list of medications. The list in the resident's record did not include Century Senior Vitamins, Phillips Colon Health Daily Probiotic, Signature Care Stool Softener 100 mg, or Signature Care Acetaminophen 325 mg.

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

Immediate Corrective Actions: The Resident Care Director met with Resident 1 to review the medications is currently taking as is a person that self-medicates. The Century Senior Vitamins and the Signature Care Acetaminophen 325 mg are current medications that the Resident takes. The RCD notified the Pharmacy and had them added to record. The Phillips Colon Health Daily Probiotic and the Signature Care Stool Softener 100 mg were discarded by the Resident, as is no longer using them.

Additional Corrective Actions: Residents that self-medicate meet with the RCD every 3 months to review medications. The RCD and Wellness Nurse will educate the Residents that self-medicate to notify them when medication changes occur, so their profile can be updated.

Ongoing Quality Assurance Actions: The Resident Care Director will send a letter to all Residents currently self-medicating that they are to notify when a medication Change occurs.

**The Resident Care Director and the Wellness Nurse are responsible for oversight of ongoing compliance.*

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

Implemented (- 07/07/2026)

183e - Storing Medications

14. 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.

183e - Storing Medications *(continued)*

Description of Violation

On May 12, 2026, it was discovered that resident 6's Alprazolam tablet #3 had a puncture on the back foil while the pill was still in place.

Repeated Violation: 4/23/2025, 2/11/2025 et al

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

Immediate Corrective Actions: On 5/12/26, the Alprazolam tablet #3 for Resident 6 was removed from the card as there was a puncture on the back foil and discarded.

Additional Corrective Actions: Med Techs and Nurses were reminded to check the backs of the cards during the Med Pass to ensure that the foil is intact. The Resident Care Director, Wellness Nurse, or Memory Care Director are to be notified if Med Techs note any issue/concern related to the cards.

Ongoing Quality Assurance Actions: The Resident Care Director sent a Memo to all Med Techs and Nurses, as weekly Medication Cart Audits will begin in Personal Care on 5/15/26, and will be completed every Friday on the 11pm to 7am shift. Memory Care Med Techs conduct weekly Med Cart Audits, every Wednesday, on the 7am to 3pm shift. Med cart audits include a MAR to cart audit, conducted for 2 Residents from each Med Cart. The RCD, Wellness Nurse, and Memory Care Director are responsible for oversight of the cart audits, and each person will conduct a monthly cart audit to spot check carts. An in-service conducted by the Resident Care Director, the Wellness Nurse, and the Executive Director, meeting will be held for Med Techs and Nurses on 6/24/26 to review Medication regulations 2600. 181 through 2600.191 to ensure regulatory compliance.

**The RCD, MCD, and Wellness Nurse are responsible for oversight of ongoing compliance.*

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

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

185a - Implement Storage Procedures

15. 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 5/12/2026, the glucometer for resident 7 shows the time as 9:59 a.m. However, the current time was 10:57 a.m. The glucometer was not properly calibrated.

Resident 8 glucometer shows a reading of 188 on 5/10/2026 at 10:51 a.m. However, the medication administration record shows the recording time as 8:51 a.m. The glucometer was not properly calibrated.

Resident 8 glucometer shows a reading of 126 on 5/10/2026 at 6:51 p.m. However, the medication administration record shows the glucometer readings as 128 on 5/10/2026 at 4:57 p.m. The glucometer was miscalibrated, and the readings were incorrect.

185a - Implement Storage Procedures (continued)

Repeated Violation: 4/23/2025, 2/11/2025 et al

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

Immediate Corrective Actions: On 5/13/26, the Resident Care Director re-calibrated the Glucometers for Resident 7 and Resident 8, then followed up with Med Techs to explain what must be done to obtain correct readings.

Additional Corrective Actions: An in-service conducted by the Resident Care Director, the Wellness Nurse, and the Executive Director, will be held for Med Techs and Nurses on 6/24/26 to review Medication regulations 2600. 181 through 2600.191 to ensure on-going regulatory compliance. The policy for Blood Glucose Monitoring Devices will also be reviewed.

Ongoing Quality Assurance Actions: The Resident Care Director and the Wellness Nurse will be responsible for weekly checks, beginning 6/15/26 to ensure the glucometers continue to work properly.

**The Resident Care Director and the Wellness Nurse are responsible for oversight of ongoing compliance.*

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

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

16. 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

Resident 8 is prescribed, Melatonin 3mg, Imodium, and Bengay as needed. On 5/12/2026, these medications were not available in the home.

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

Immediate Corrective Actions: On 5/12/26, the Resident Care Director spoke to the Resident and ordered Melatonin 3mg from the Pharmacy. It was delivered timely. After meeting with the Resident, the Resident Care Director reached out to the Physician and the Imodium and Bengay were discontinued on 5/14/26.

Additional Corrective Actions: The Resident Care Director sent a Memo to all Med Techs and Nurses, as weekly Medication Cart Audits will begin in Personal Care on 5/15/26, and will be completed every Friday, on the 11pm to 7am shift. Med cart audits include a MAR to cart audit, conducted for 2 Residents from each Med Cart. The RCD, Wellness Nurse, and Memory Care Director are responsible for oversight of the cart audits, and each person will conduct a monthly cart audit to spot check carts.

Ongoing Quality Assurance Actions: An in-service conducted by the Resident Care Director, the Wellness Nurse, and the Executive Director, will be held for Med Techs and Nurses on 6/24/26 to review Medication regulations 2600. 181 through 2600.191 to ensure regulatory compliance.

**The Resident Care Director and the Wellness Nurse are responsible for oversight of ongoing compliance.*

185a - Implement Storage Procedures *(continued)*

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

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

187b - Date/Time of Medication Admin.

17. 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 8 is prescribed Eucerin Plus cream, applied topically to B/L extremities two times a day for dry skin. However, on 5/12/2026, the medication was not available at the facility, and staff person A recorded it was administered at 9:00 a.m.

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

Immediate Corrective Actions: The Resident Care Director purchased the Eucerin Plus Cream for the Resident on 5/12/26.

Additional Corrective Actions: The Resident Care Director met with Staff Person A on 5/12/26 to provide education and review expectations related to [redacted] role and responsibilities. The RCD provided documented coaching based on the situation that occurred.

Ongoing Quality Assurance Actions: Staff person A will also receive additional training related to Medication regulations 2600. 181 through 2600.191 to ensure regulatory compliance at the Med Tech and Nurses Meeting/In-service to be held on 6/24/26.

**The Resident Care Director and the Wellness Nurse are responsible for oversight of ongoing compliance.*

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

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

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

Resident 8 is prescribed Eucerin Plus cream, applied topically to B/L extremities two times a day for dry skin. However, this medication was not administered to resident 8 on 5/12/2026 at 9:00 a.m. because the medication was not available in the home.

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

Immediate Corrective Actions: The Resident Care Director purchased the Eucerin Plus Cream for the Resident on 5/12/26.

187d Follow Prescriber's Orders (continued)

Additional Corrective Actions: The Resident Care Director sent a Memo to all Med Techs and Nurses, as weekly Medication Cart Audits will begin in Personal Care on 5/15/26, and will be completed every Friday, on the 11pm to 7am shift. Med cart audits include a MAR to cart audit, conducted for 2 Residents from each Med Cart. The RCD, Wellness Nurse, and Memory Care Director are responsible for oversight of the cart audits, and each person will conduct a monthly cart audit to spot check carts.

Ongoing Quality Assurance Actions: An in service conducted by the Resident Care Director, the Wellness Nurse, and the Executive Director, will be held for Med Techs and Nurses on 6/24/26 to review Medication regulations 2600. 181 through 2600.191 to ensure regulatory compliance.

**The Resident Care Director, the Memory Care Director, and the Wellness Nurse are responsible for oversight of ongoing compliance.*

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

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

224a - Preadmission Screen Form

19. 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 2 was admitted to the home on [redacted] however, the resident's preadmission screening form was completed on [redacted]

Resident 9 was admitted to the home on [redacted] however, the resident's preadmission screening form was completed on [redacted]

Repeated Violation: 2/11/2025 et al

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

Immediate Corrective Actions: Both Resident 2 and Resident 9 were admitted prior to the recent transition in ownership and management of the community. The admission process has been updated.

Additional Corrective Actions: The community uses a "New Resident On Boarding Checklist" once the potential resident places a deposit on an apartment. All required paperwork is listed and must be completed in the specified time frame. Each department leader is required to sign off on the checklist.

Ongoing Quality Assurance Actions: The Executive Director maintains the checklist, and it's reviewed daily to keep all the necessary paperwork on track. The Resident Care Director and Memory Care Director will be responsible for providing the prescreen once they complete an assessment. A file audit will be completed by 6/30/26.

**The Resident Care Director and the Memory Care Director are responsible for the oversight of ongoing compliance.*

224a - Preadmission Screen Form *(continued)*

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

Implemented (- 07/07/2026)

225a - Assessment 15 Days

20. 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

The assessment for resident 1, dated , does not indicate that the resident has a need for an enabler.

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

Immediate Corrective Actions: When the RCD completed the assessment for admission of Resident 1 to the community, there was no mention of an enabler bar. Going forward, RCD will question potential residents about the use of enabler bars.

Additional Corrective Actions: The Executive Director will ask the family member/responsible person a follow-up question about the use of an enabler bar when completing a review of the 10 Elements of a Care Partnership. This is an opportunity to ensure compliance with safety and regulatory guidelines.

Ongoing Quality Assurance Actions: An audit will be completed by 6/30/26 to ensure that any current resident with an enabler bar has it listed on their assessment. The Resident Care Director and Memory Care Director are responsible for completing the assessment timely and review for accuracy.

**The MCD and RCD are responsible for oversight of ongoing compliance.*

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

Implemented (- 07/07/2026)

227c - Support Plan Revision

21. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident 2's assessment was completed on however, the resident's support plan was not completed until .

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

Immediate Corrective Actions: The Memory Care Director (MCD) acknowledged that the Resident's support plan was not completed timely. MCD planned for Resident 2 to be seen by the Physician on A new RASP was completed, and going forward, the Resident's assessment date will be based on this update, unless there is a significant change noted.

227c - Support Plan Revision (continued)

Additional Corrective Actions: Our Regional Vice President of Resident Care continues to work with us providing a Monthly Compliance report so we can measure our performance and track our progress.

Ongoing Quality Assurance Actions: The community uses an Electronic Health Record, and we will review all RASP expiration dates and add them to the EHR to ensure compliance. We review and update all Residents assessments every 6 months to ensure ongoing compliance. The Memory Care Director (MCD) and Resident Care Director (RCD) are responsible for checking the dashboard to identify the timeline for completing the RASP.

**The MCD and RCD are responsible for oversight of ongoing compliance.*

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

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

252 - Record Content

22. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).

252 - Record Content *(continued)*

25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident 2's and resident 10's records do not include an initial intake assessment or the annual assessment.

Resident 11's record does not include an initial preadmission screening or nitial intake assessment or the annual assessment.

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

Immediate Corrective Actions: Residents 2, 10, and 11 were admitted prior to the recent transition in ownership and management of the community. When setting up our Electronic Health Record system, multiple files were uploaded to the system, provided we had access to the Residents' initial paperwork. An initial intake assessment or the annual assessment for Residents 2 and 10 were not located in their file, and Resident 11 was missing an initial preadmission screening or initial intake assessment or the annual assessment.

Additional Corrective Actions: The community uses a "New Resident On-Boarding Checklist" once the potential resident places a deposit on an apartment. All required paperwork is listed and must be completed in the specified time frame. Each department leader is required to sign off on the checklist.

Ongoing Quality Assurance Actions: The Executive Director maintains the checklist, and it's reviewed daily to keep all the necessary paperwork on track. The Resident Care Director and Memory Care Director are responsible for completing the prescreen once they complete an initial assessment. The community uses an Electronic Health Record, and we will review all RASP expiration dates and add them to the EHR to ensure compliance. We review and update all Residents assessments every 6 months to ensure ongoing compliance.
A file audit will be completed by 6/30/26.

**The MCD and RCD are responsible for oversight of ongoing compliance.*

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

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