

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

September 22, 2026

[REDACTED], EXECUTIVE DIRECTOR
PARAMOUNT SENIOR LIVING AT FAYETTEVILLE LLC
[REDACTED]
[REDACTED]

RE: PARAMOUNT SENIOR LIVING AT
CHAMBERSBURG ROAD
6375 CHAMBERSBURG ROAD
FAYETTEVILLE, PA, 17222
LICENSE/COC#: 33383

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]
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: PARAMOUNT SENIOR LIVING AT CHAMBERSBURG ROAD
License #: 33383 **License Expiration:** 04/16/2027
Address: 6375 CHAMBERSBURG ROAD, FAYETTEVILLE, PA 17222
County: ADAMS **Region:** CENTRAL

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: PARAMOUNT SENIOR LIVING AT FAYETTEVILLE LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-2 **Date:** 11/04/2010 **Issued By:** Franklin Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 81 **Waking Staff:** 61

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint **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: 100 **Residents Served:** 53

Secured Dementia Care Unit

In Home: Yes **Area:** lower level SDCU **Capacity:** 24 **Residents Served:** 13

Hospice

Current Residents: 7

Number of Residents Who:

Receive Supplemental Security Income: 1 **Are 60 Years of Age or Older:** 53
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 28 **Have Physical Disability:** 0

Inspections / Reviews

05/12/2026 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 06/07/2026

Inspections / Reviews (*continued*)

06/10/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/22/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 06/17/2026

06/24/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/22/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 07/23/2026

09/22/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/22/2026

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 7/3/25 at 8:00 PM, Resident #1 struck Resident #2 in the stomach multiple times. This incident was observed by staff person A. This incident of abuse was not reported to the local area agency on aging.

Plan of Correction

Accept () - 06/24/2026)

1. *On 5/20/26 Executive Director and Resident Care Manager were educated on compliance with this regulation.*
2. *Starting the week of 6/1/26, the Executive Director or designee will complete weekly audits of all resident-to-resident incidents to make sure they are reported to the local area agency on aging x4 weeks.*
3. *The Executive Director completed additional training regarding resident abuse and reporting 6/2/26 through PA.gov.*

***On 6/15/2026 incident between two residents were reported to APS, to ()*

4. *Starting the week of 6/29/26, the Executive Director or designee will perform monthly audits to ensure compliance with the regulation.*
5. *On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.*
6. *All documentation will be kept.*

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

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 2/12/26, Resident #3 was prescribed nystatin powder, apply to groin BID for 10 days or until resolved. This medication was not recorded on the resident's medication administration record and therefore was not given as prescribed. This medication error was not reported to the Department.

On 2/3/26, a protective services investigator from the Adams County Office on Aging was at the home investigating allegations of neglect of Resident #4. The home did not report these allegations of neglect to the Department.

Plan of Correction

Accept () - 06/24/2026)

1. *On 6/2/26, the Executive Director and Resident Care Manager were educated on compliance with this regulation. Moving forward the Executive Director and Resident Care Manager are aware visits from the Office of Aging investigating allegations of abuse must be reported to DHS.*

***On 6/12/26 DHS reports were made for resident #3 and resident #4.*

16c Written Incident Report (continued)

2. Will be audited based off of occurrence of an abuse report.
3. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
4. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

17 - Record Confidentiality**3. 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 5/12/26 at 9:11 AM, a computer terminal atop a medication cart in the center of the main hallway was unlocked, unattended, and allowed access to the electronic medication administration report (eMAR) system including resident names, prescribed medications, and diagnosis. At 9:16 AM, staff person B's office was open, unattended, and allowed access to resident records within. At 9:24 AM, there were binders sitting unlocked, unattended, and accessible atop the desk in the secured dementia care unit. The binders contained protected health information like resident names, prescribed medications, and diagnosis.

Repeated Violation 9/10/24

Plan of Correction

Accept () - 06/10/2026)

1. Upon notification from surveyor that MD binder was left on the nurse's desk in MC the binders were locked in the chart room.
2. Upon notification from the surveyor that laptops were not closed and they were able to access resident information all staff was instructed to close their laptops when not using them.
3. On 5/20/26 Executive Director, Resident Care Manager and Assistance Resident Care Manager were educated on compliance with this regulation.
4. On 5/21/26 all nurses and med techs were educated on Confidentiality of Resident Records especially locking up MD binder and closing laptops when not in use.
5. Starting the week of 6/8/26, the Executive Director or designee will perform daily audits Monday Friday x4 weeks of facility for compliance by rounding all units and areas of facility to ensure continued compliance.
6. Starting the week of 7/6/29 audits will be completed once weekly. Non compliance issues will be investigated and corrected with education and/or progressive discipline.
7. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
8. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

65a - FS Orientation 1st Day

4. Requirements

2600.

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

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

Description of Violation

Staff person C, whose first day of work was [REDACTED], did not receive orientation on evacuation procedures, staff duties and responsibilities during fire drills, designated meeting spot during fire drills, smoking safety procedures and the home's smoking policy, location and use of fire extinguisher, smoke detectors and fire alarms, and telephone use and notification of emergency services until [REDACTED]

Plan of Correction**Accept ([REDACTED] - 06/10/2026)**

1. On 6/1/26, the HR Director was educated on compliance with this regulation. HR Assistant to be educated 6/8/26, [REDACTED]
2. Starting the week of 6/8/26, the Executive Director or designee will audit all new hire personnel files to ensure compliance with regulation x4 weeks.
3. Starting the week of 7/6/26 audits will be completed monthly of 5 random new hires personnel files to ensure compliance with regulation.
4. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
5. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented ([REDACTED] - 09/21/2026)**65b Rights/Abuse 40 Hours****5. Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).

Description of Violation

Staff person C, hired [REDACTED], did not receive training in resident rights or mandatory reporting of abuse and neglect until [REDACTED]

Plan of Correction**Accept ([REDACTED] - 06/10/2026)**

1. On 6/1/26, the HR Director was educated on compliance with this regulation. HR Assistant will be educated on 6/8/26, [REDACTED].
2. Starting the week of 6/8/26, the Executive Director or designee will audit all new hire personnel files to ensure

65b Rights/Abuse 40 Hours (continued)

compliance with regulation x4 weeks.

3. Starting the week of 7/6/26 audits will be completed monthly of random new hires personnel files to ensure compliance with regulation.

4. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.

5. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

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.

Description of Violation

Direct care staff person D received only 10.75 hours of annual training in the 2025 calendar training year.

Repeated Violation 9/10/24

Plan of Correction

Accept () - 06/10/2026)

1. On 5/20/26, Executive Director, Resident Care Manager and Assistance Resident Care Manager were educated on compliance with this regulation.

2. On 5/21/26, all staff were educated on the requirement to complete 12 hours of annual training, education is be provided the 3rd Thursday of each month at the nursing meeting.

3. By 5/29/26, ancillary staff (maintenance and activities that transport residents) will be given packets for 6 hours annual trainings to be completed by 6/30/26.

4. Starting 5/21/26, the Executive Director or designee will monitor attendance at each monthly nursing meeting and make sure the staff that do not attend the scheduled meeting complete the monthly training by the end of the month.

5. By 6/12/26 the Executive Director will complete an audit of current staff to make sure they have completed the monthly trainings for Jan through May 2026. Any missing educations will be completed by 6/30/26.

6. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.

7. All documentation will be kept

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

65f - Training Topics**7. Requirements**

2600.

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

6. Safe management techniques.

65f - Training Topics (continued)

Description of Violation

Direct care staff D and E did not receive training in safe management techniques during the 2025 calendar training year.

Plan of Correction

Accept () - 06/10/2026)

1. On 5/20/26, Executive Director, Resident Care Manager and Assistance Resident Care Manager were educated on compliance with this regulation.
2. On 5/21/26, all staff were educated on the requirement to complete 12 hours of annual training and topics, education is be provided the 3rd Thursday of each month at the nursing meeting.
3. Starting 5/21/26, the Executive Director or designee will monitor attendance at each monthly nursing meeting and make sure the staff that do not attend the scheduled meeting complete the monthly training by the end of the month.
4. By 6/12/26 the Executive Director will complete an audit of current staff to make sure they have completed the monthly trainings for Jan through May 2026. Any missing educations will be completed by 6/30/26.
5. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
6. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

65g - Annual Training Content

8. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Staff person D did not receive training in The Older Adults Protective Services Act during the calendar training year January 2025 through December 2025.

Staff person F did not receive annual training in falls and accident prevention during the calendar training year January 2025 through December 2025.

Plan of Correction

Accept () - 06/10/2026)

1. On 5/20/26, Executive Director, Resident Care Manager and Assistance Resident Care Manager were educated on compliance with this regulation.
2. On 5/21/26, all staff were educated on the requirement to complete 12 hours of annual training and topics, education is be provided the 3rd Thursday of each month at the nursing meeting.
3. Starting 5/21/26, the Executive Director or designee will monitor attendance at each monthly nursing meeting and make sure the staff that do not attend the scheduled meeting complete the monthly training by the end of the month.

65g - Annual Training Content (continued)

4. By 6/12/26 the Executive Director will complete an audit of current staff to make sure they have completed the monthly trainings for Jan through May 2026. Any missing educations will be completed by 6/30/26.
5. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
6. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

89b - Hot Water Temperature**9. Requirements**

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 5/12/26 at 11:05 AM, the water temperature at the bathroom sink of Residents #5 and #6 measured 131 degrees Fahrenheit.

Plan of Correction

Accept () - 06/10/2026)

1. On 5/12/26, the surveyor informed staff that the water temperature in 2 rooms measured 131 degrees.
2. The Maintenance Director regulated the mixing valve to bring down the temperature below 120 degrees, the water temperature was checked twice on 5/12/26 to ensure compliance.
3. Starting 5/13/26 water temps have been checked 3x/daily to ensure compliance with this regulation by maintenance personnel. Audits will continue 3x/daily through 6/8/26 then 3x/week through 7/23/26 then weekly.
4. On 6/2/26, the Maintenance Director and Maintenance Assistant were educated on compliance with this regulation.
5. New mixing valve excepted to be delivered 6/4/26 and will be replaced by maintenance. After valve is replaced water temperatures will be audited daily x4 weeks.
6. Starting the week of 7/6/26 water temperatures will be monitored weekly.
7. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
8. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

103e - Left Overs**10. 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

There were three and a half trays of lemon bars that were not labeled or dated, and two tubs of something labeled "P" that were not dated stored in the kitchen.

Repeated Violation - 11/19/24

103e Left Overs (continued)

Plan of Correction

Accept () - 06/10/2026

1. Surveyor notified the Executive Director at the end of the day if this violation, the Dietary Manager was verbally educated all leftovers must be labeled and dated.
2. On 5/20/26, the Dietary Manager was again educated on compliance with this regulation.
3. On 5/20/26, the Dietary Manager educated his staff on the need to label and date all left over food.
4. Starting the week of 6/8/26, the Dietary manager or designee perform random audits of kitchen area to make sure all leftover food is labeled and dated 3x/week x4 weeks.
5. Starting the week of 7/6/26, the Dietary Manager of designee will complete audits once weekly to ensure compliance.
5. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
6. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026

127a - Portable Space Heaters

11. Requirements

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

On 5/12/26, at 11:05 AM, a space heater was plugged into the wall outlet of Resident #5 and Resident #6's bathroom. Resident #6 reports () uses the space heater "quite often."

Plan of Correction

Accept () - 06/10/2026

1. On 5/12/26 upon notification from the surveyor of the space heater that was found the Executive Director educated the resident that space heaters are not permitted in personal care facilities and it was removed.
2. On 5/13/26, the Executive director checked all resident rooms for space heaters, no others were found.
3. On 5/20/26, Executive Director, Resident Care Manager and Assistance Resident Care Manager were educated on compliance with this regulation.
4. On 5/21/26, all nurses and med techs were educated on space heater not permitted in personal care and if one is found in a resident's room it is to be removed. Nurses and med techs are to educate the resident on the regulation, document the item was found, that the resident was educated and the item was removed.
5. Starting the week of 6/8/26, the Executive Director or designee will check 5 random rooms once weekly for the presence of space heaters x4 weeks.
6. Starting the week of 7/6/26, audits will be completed weekly during rounds.
6. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
7. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026

132b - Safety Inspection/Fire Drill

12. Requirements

132b Safety Inspection/Fire Drill (continued)

2600.

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

Description of Violation

The last fire safety inspection and supervised fire drill conducted by a fire safety expert was on 4/2/26. The previous fire safety inspection and supervised fire drill conducted by a fire safety expert was on 2/25/25.

Plan of Correction**Accept () - 06/10/2026)**

1. *Notified by the surveyor the 2026 annual fire inspection and fire drill was completed on 4/2/26 which was late.*
2. *On 5/21/26, the Maintenance Director was educated on compliance of this regulation.*
2. *The Executive Director added a calendar reminder for Nov 2026 to schedule the annual fire safety inspection and fire drill to be completed before 4/2/27.*
3. *On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.*
4. *All documentation will be kept.*

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)**132d Evacuation****13. 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 fire drill conducted on 3/16/26 required 4 minutes and 8 seconds to evacuate to a fire safe area. The home did not have a maximum safe evacuation time specified in writing by a fire safety expert allowing for an evacuation time exceeding 2 minutes and 30 seconds.

Plan of Correction**Accept () - 06/10/2026)**

1. *Notified by the surveyor the 2026 annual fire inspection and fire drill was completed late which causes the evacuation time to revert to 2.5 minutes until annual fire inspection and drill is current with accurate evacuation time.*
2. *On 5/21/26, the Maintenance Director was educated on compliance of this regulation.*
3. *The Executive Director added a calendar reminder for Nov 2026 to schedule the annual fire safety inspection and fire drill to be completed by April 2027.*
4. *On 7/23/26 the compliance will be reviewed during the quarterly QA meeting.*
5. *All documentation will be kept.*

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)**141b1 Annual Medical Evaluation****14. Requirements**

141b1 - Annual Medical Evaluation (continued)

2600.

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

Description of Violation

Resident #7's most recent medical evaluation was completed on [REDACTED] however, the resident's previous medical evaluation was completed on [REDACTED]

Resident #8's most recent medical evaluation was completed on [REDACTED] however, the resident's previous medical evaluation was completed on [REDACTED]

Repeated Violation - 11/19/24, 9/10/24

Plan of Correction

Accept [REDACTED] - 06/10/2026)

1. Surveyor notified the Executive Director of two late DMEs noted during review.
2. On 5/20/26, Executive Director, Resident Care Manager and Assistance Resident Care Manager were educated on compliance with this regulation.
3. By 5/29/26, the Executive Director or designee will audit all current resident DMEs to confirm compliance. All current DMEs are within compliance.
4. Starting 6/8/26, the Executive Director will review and initial all completed DMEs to ensure compliance.
5. Starting 5/26/26, all DMEs completed will be recorded on the DME/RASP tracker indicating compliance with the annual medical evaluation. The Resident Care Manager will audit the binder monthly to ensure compliance.
6. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
7. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented [REDACTED] - 09/21/2026)

144b - Policy on Smoking

15. Requirements

2600.

144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

The home's smoking policy states that Paramount Senior Living facilities are a smoke free environment, smoking is not permitted in any part of the building or on its property. However, on 5/12/26, at 1:15 PM, there was a smoking area behind the personal care home that is used by staff. The area contains a metal table, metal chairs, and a permanent shelter-like tent. This area was described as the "smoking shed."

Plan of Correction

Accept [REDACTED] - 06/10/2026)

1. On 5/21/26, all staff was educated on the smoking policy. Paramount is a smoke free facility, smoking is only permitted off of the property or in your personal vehicle. There are no designated smoking areas.
2. A smoking clarification memorandum was posted at the receptionist desk on 6/2/26 to remind staff, residents and visitors of the policy.
3. Starting the week of 6/1/26, the Executive Director or designee will do random facility walk arounds to ensure compliance with facility smoking policy 3x/week x 4 weeks.
4. Starting the week of 7/6/26, the Executive Director or designee will do random facility walk arounds to ensure compliance with facility smoking policy once weekly.

144b Policy on Smoking (continued)

5. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
6. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

164c - Resident Refusal Eat/Drink**16. Requirements**

2600.

164.c. If a resident refuses to eat or drink continuously during a 24-hour period, the resident's primary care physician and the resident's designated person shall be immediately notified.

Description of Violation

From 1/25/26 to 1/31/26, Resident #4 refused to eat. The home notified the resident's primary medical provider on 1/26/26, however, did not obtain a plan of treatment. The home did not notify the resident's primary medical provider again until 2/4/26.

Plan of Correction

Accept () - 06/10/2026)

1. On 5/21/26, all nurses were educated on the need to immediately notify the resident's primary care provider and obtain a plan of treatment if the resident refuses to eat or drink continuously during a 24 hour period. Med techs were educated to make nurse aware of this so they can notify primary care physician.
2. Starting the week of 6/8/26, the Resident Care Manager or Designee will audit the 24 hour report in PCC and make sure the resident's primary care physician is notified if they do not eat or drink for 24 hours and a plan of treatment was obtained daily Monday Friday x4 weeks.
3. Starting the week of 7/6/26, the audits will be 3x/weekly through 7/23/26.
4. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
5. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

183b - Meds and Syringes Locked**17. 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 5/12/26 at 4:41 PM, two tubes of protect zinc oxide paste skin protectant, prescribed to Resident #8, were unlocked, unattended, and accessible on the resident's nightstand. Resident #8 is not assessed to self administer medications.

On 5/12/26 at 11:00 AM, a bottle of Mucus relief DM 1200mg guaifenesin/60mg dextromethorphan hbr extended release tablets was unlocked and accessible in the top drawer of the dresser in room () Resident #5 who resides in the room, is not assessed to self administer medications.

On 5/12/26 at 3:30 PM, mucus relief 1200mg guaifenesin/60mg dextromethorphan hbr extended release tablets, a

183b - Meds and Syringes Locked (continued)

bottle of acetaminophen 325mg tablets, and a bottle of ibuprofen 200mg tablets were unlocked, unattended and accessible in the top drawer of the dresser by the window in Resident #5's bedroom. Resident #5 is not assessed to self-administer medications.

Repeated Violation - 9/10/24

Plan of Correction

Accept () - 06/10/2026

1. On 5/12/26 upon notification from surveyor that 2 tubes of zinc oxide paste skin protectant was on resident's night stand unlocked, unattended and accessible the tubes were removed from room.
2. On 5/12/26 at 11am upon notification that a bottle of Mucus Relief DM 1200mg guaifenesin/60mg dextromethorphan hbr extended-release tablets unlocked and accessible on the top drawer of the dresser, the Executive Director spoke with the resident and reviewed the regulation with .
3. On 5/12/26 at 11am upon notification that a bottle of Mucus Relief DM 1200mg guaifenesin/60mg dextromethorphan hbr extended-release tablets, a bottle of acetaminophen 325mg tablets and a bottle of ibuprofen 200mg tablets unlocked and accessible on the top drawer of the dresser, the Executive Director spoke with the resident and reviewed the regulation with again.
4. On 5/13/26, the Executive Director check resident room and no medications were unlocked, unattended or accessible continued to check daily for 1 week.
5. Starting the week of 5/25/26, weekly audits to be completed through 7/23/26.
6. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
7. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026

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 4/12/26, there are blister cards of 1 MG and 5 MG melatonin tablets prescribed for Resident #5; however, these medications were discontinued on 4/29/26.

On 4/12/26, the following medications were present in a trashcan in the main spa/bathroom:

- Resident #3's nystatin powder; staff person B stated Resident #3's course of treatment was completed
- Resident #7's athletes foot aer 2% and calamine lotion 8.8%; staff person B stated Resident course of treatment was completed
- Resident #9's diclofenac sodium topical gel 1%; Resident #9 is no longer a resident as of
- Resident #10's nystatin powder; staff person B stated #10's course of treatment was completed

Plan of Correction

Accept () - 06/10/2026

1. On 5/12/26 upon notification from the surveyor that 2 blister cards of melatonin were present in the medication cart that were discontinued staff removed the cards and properly disposed of the medication.
2. On 5/12/26 upon notification from the surveyor that 5 treatments were present in main spa/bathroom trashcan, 4 that treatments were completed and 1 belonged to a someone no longer a resident, the Executive Director called

183d - Prescription Current (continued)

the pharmacy and asked how to properly dispose of treatments. Treatments were then disposed of via infectious waste containers.

3. On 5/21/26, all nurses and med techs were educated on that when medications are discontinued or completed they are to be removed from the carts and properly disposed of.
4. By 6/12/26 all medication carts will be audited by the Executive Director or designee to ensure compliance.
5. Starting the week of 6/15/26, the Resident Care Manager or designee will audit one medication cart per week using the Medication Cart/Room Audit form.
6. Starting 6/22/26, the current quarter, a pharmacy representative will audit all medication carts to ensure compliance quarterly.
7. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
8. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

183e - Storing Medications**19. 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 4/12/26, a blister card containing Resident 11's prescribed Lorazepam Tab 0.5 mg tablets had multiple punctures exposing the medications to potential loss or contamination. One of the punctured blisters had tape on it and the tablet was adhered to the tape.

Repeated Violation - 9/10/24

Plan of Correction

Accept () - 06/10/2026)

1. On 5/12/26 upon notification from Surveyor that a blister card containing Lorazepam 0.5mg tablets had multiple punctures exposing the medications to potential loss or contamination and one of the punctures had tape on it and the tablet was adhered to the tape, medications in the blisters with holes in them and the taped blister were destroyed by Executive Director and med tech.
2. On 5/21/26, all nurses and med techs were educated on compliance that narcotic blister packs cannot have tears in them or be taped. Medications in blisters that are torn must be destroyed with a second nurse/med tech.
3. On 5/12/26 all narcotic blister packs were audited by the Executive Director to ensure compliance.
4. Starting the week of 6/8/26, the Resident Care Manager or designee will audit one medication cart per week using the Medication Cart/Room Audit form.
5. Starting 6/22/26, the current quarter, a pharmacy representative will audit all medication carts to ensure compliance quarterly.
6. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
7. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

183e Storing Medications (*continued*)*Implemented () - 09/21/2026)*

183f Discontinued Medications

20. Requirements

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On 5/12/26 at 11:20 AM, the following medications were disposed of in the trashcan attached to a medication cart stored in the main spa/bathroom. Disposing of medications in the trash is not an approved method of destruction according to the Department of Environmental Protection and Federal and State regulation.

- Resident #3's nystatin powder
- Resident #7's athlete's foot aer 2% and calamine lotion 8.8%
- Resident #9's diclofenac sodium topical gel 1%
- Resident #10's nystatin powder

Plan of Correction*Accept () - 06/10/2026)*

1. On 5/12/26 upon notification from the Surveyor that treatment medications were disposed of in the trashcan attached to the medication cart stored in the main spa/bathroom the Executive Director called the pharmacy to inquire about the correct destruction on treatment medications. Treatment medications were then removed from trashcan and disposed of via infectious waste container.
2. On 5/21/26, all nurses and med techs were educated on compliance that when treatment medications are discontinued or completed they are to be disposed of properly via infectious waste containers.
3. Starting the week of 6/8/26, the Resident Care Manager will do daily audits Monday-Friday of the trashcan on the medication cart in the main spa/bathroom x4 weeks.
4. Starting the week of 7/6/26, audits will be completed once weekly to ensure compliance.
5. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
6. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

184a Resident's Meds Labeled

21. Requirements

2600.

- 184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for Resident #5's Rosuvastatin 40 MG tablets, take 1 tablet at bedtime, differs from the order prescribed on 5/12/26 which is for 20 MG tablets, take 2 tablets (40 MG) orally at bedtime.

184a - Resident's Meds Labeled (continued)

There are single-dose containers of Remedy Protect Zinc Oxide sitting on the side of the medication cart stored in the main spa/bathroom. These containers are not labeled with the name(s) of the resident(s) for whom they are prescribed.

On 5/12/26 at 11:20 AM, Resident #10's nystatin powder had been disposed of in a trashcan. The medication was ordered on 3/23/26, to be applied to [REDACTED] twice daily for 7 days then twice daily as needed. The medication was administered for 7 days then changed to prn administration. This medication did not have a change order sticker on the label.

Repeated Violation - 9/10/24

Plan of Correction**Accepted ([REDACTED] - 06/10/2026)**

1. On 5/12/26 upon notification from the Surveyor that the label for Rosuvastatin 40mg, take 1 tablet at bedtime differed from the order prescribed on 5/12/26 which is 20mg tablets, take 2 tablets (40mg) orally at bedtime a change of directions sticker was added to card and the pharmacy was called and instructed to notify staff when the medication order changes because availability of medication. When the new card of 40mg was delivered the 20mg card was returned to the pharmacy.
2. On 5/12/26 upon notification from the Surveyor that single dose containers of Remedy Protect Zinc Oxide sitting on the side of the medication cart stored in the main spa/bathroom were not labeled with the resident name for who it was prescribed, the Executive Director labeled the single dose containers.
3. On 5/12/26 upon notification from the Surveyor that nystatin powder had been disposed of in the trashcan, the medication was ordered twice daily for 7 days then changed to prn administration and it did not have a change order sticker on the label. New order was obtained and medication was ordered from pharmacy.
4. On 5/21/26, all nurses and med techs were educated on compliance that anytime a medication changes, the dose or directions they must put a change of directions sticker on the medication and all treatment medications must be labeled with resident name.
5. By 6/12/26 all medication carts will be audited by the Resident Care Manager or designee to ensure compliance.
6. Starting the week of 6/15/26, the Resident Care Manager or designee will audit one medication cart per week using the Medication Cart/Room Audit form.
7. Starting 6/22/26, the current quarter, a pharmacy representative will audit all medication carts to ensure compliance quarterly.
8. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
9. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented ([REDACTED] - 09/21/2026)**184b - Labeling OTC/CAM****22. Requirements**

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 4/12/26, a bottle of Nature Made D3 2000 IU 50 MCG supplement belonging to Resident #12 was not labeled with the resident's name. A bottle of D3 50 MCG supplement, 2000 IU, and a bottle of B12 500 MCG supplement

184b - Labeling OTC/CAM (continued)

belonging to Resident #13 were not labeled with the resident's name.

Plan of Correction

Accept () - 06/10/2026)

1. On 5/12/26 upon notification from the Surveyor that three bottles of OTC medications were not labeled with the resident names for whom the medications were prescribed, the Executive Director added the correct resident names to the bottles.

2. On 5/21/26, all nurses and med techs were educated on compliance that the resident name number and were reminded to opened date must be on all bottles of medications.

3. By 6/12/26 all medication carts will be audited by the Resident Care Manager or designee to ensure compliance.

4. Starting the week of 6/15/26, the Resident Care Manager or designee will audit one medication cart per week using the Medication Cart/Room Audit form

5. Starting 6/22/26, the current quarter, a pharmacy representative will audit all medication carts to ensure compliance quarterly.

6. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.

7. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

185a - Implement Storage Procedures**23. 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 blood sugar testing 4 times daily. A reading of 250 that is recorded on the medication administration record for 5/11 at 18:52 is not stored in the resident's meter.

The home has a policy to delete readings from glucometers after the reading is documented. Resident #8's glucometer had five readings stored in memory. Resident #14's glucometer had only five readings stored in memory. Resident #15's glucometer had 6 readings stored in memory.

On 4/12/26 at 11:30 AM, multiple glucometers and testing supplies were stored in a treatment cart in the main spa/bathroom. These included:

- a prodigy auto code glucometer loose in the bottom drawer with no label to whom it belongs*
- four labeled cases containing glucometers not labeled to whom they belong*
- an unlabeled glucometer case with unlabeled test strips inside*
- an unlabeled glucometer case with an prodigy auto code glucometer with no label to whom it belongs*

Repeated Violation - 9/10/24

Plan of Correction

Accept () - 06/10/2026)

1. On 5/12/26 Surveyor notified staff that three resident glucometers had only a limited number of readings store, the current facility policy was updated.

185a Implement Storage Procedures (continued)

2. On 5/12/26 upon notification from Surveyor that multiple unlabeled glucometers and supplies were found in the medication cart in the main spa/bathroom, the Executive Director disposed of these glucometers and supplies.
3. On 5/21/26 nurses and med techs were educated on compliance that all glucometers must have the resident's name on and be in their own bags, all readings on the glucometer must match the readings in PCC, do not delete readings from the glucometers any longer and when orders for glucometers are discontinued or the resident passes away the glucometers are to be disposed of.
4. By 6/12/26 all medication carts will be audited by the Resident Care Manager or designee to ensure compliance.
5. Starting the week of 6/15/26, the Resident Care Manager or designee will audit one medication cart per week using the Medication Cart/Room Audit form.
6. Starting 6/22/26, the current quarter, a pharmacy representative will audit all medication carts to ensure compliance quarterly.
7. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
8. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

187b - Date/Time of Medication Admin.**24. 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 #7 is prescribed calamine lotion and miconazole 2% spray, both to be applied to affected areas twice daily. Resident #7's medication administration record does not include the initials of the staff who administered these medications on 3/28 and 3/14/26.

Plan of Correction

Accept () - 06/10/2026)

1. Upon notification from the Surveyor that calamine lotion and miconazole spray did not include the initials of the staff who administered these treatment medications for 2 days these treatment medications were discontinued prior to this survey. Executive Director notified the MD and asked the MD to assess resident to see if he needed any further treatment, no new orders were received.
2. On 5/21/26, all nurses and med techs were educated on compliance that the date and time will be recorded when treatments are completed.
3. Starting 6/8/26 the Resident Care Manager or designee will review the prior day's MARs for all residents to ensure compliance.
4. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
5. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

187d - Follow Prescriber's Orders**25. Requirements**

187d - Follow Prescriber's Orders (continued)

2600.

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

Description of Violation

On 2/12/26, Resident #3 was prescribed nystatin powder, apply to groin BID for 10 days or until resolved. Staff person B states this medication was not recorded on the resident's medication administration record and therefore was not given as prescribed.

Repeated Violation - 9/10/24

Plan of Correction

Accept () - 06/10/2026)

- 1. Upon notification from Surveyor the resident was ordered nystatin powder which was not recorded on the resident's medication administration record and therefore was not given as prescribed, the Executive Director notified the MD and asked the MD to assess resident to see if she needed any further treatment, no redness noted and no new orders were received.*
- 2. On 5/21/26, all nurses and med techs were educated on compliance that while waiting for the pharmacy to enter new orders and until they are confirmed if the medication is in the facility administration is to be documented in a progress note in PCC.*
- 3. On 6/3/26 the Corporate RN, Executive Director and Resident Care Manager had a conference call with the pharmacy regarding orders not entered into PCC. The pharmacy was not receiving some of their faxes, their IT department had this issue resolved as of 5/27/26.*
- 4. Starting the week of 6/8/26, the Resident Care Manager or designee will audit all new orders twice weekly when the CRNP is here completing her rounds to ensure the orders were entered into PCC by the pharmacy for administration by the nurses/med techs x4 weeks.*
- 5. Starting the week of 7/6/26, the Resident Care Manager or designee will audit all new orders weekly ensure compliance through 7/23/25.*
- 6. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.*
- 7. All documentation will be kept.*

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/15/2026)

188b - Medication Error Reporting**26. Requirements**

2600.

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

On 2/12/26, Resident #3 was prescribed nystatin powder, apply to groin BID for 10 days or until resolved. Staff person B states this medication was not recorded on the resident's medication administration record and therefore was not given as prescribed. This medication error was not reported to the prescriber.

Plan of Correction

Accept () - 06/10/2026)

- 1. Upon notification from Surveyor the resident was ordered nystatin powder which was not recorded on the resident's medication administration record and therefore was not given as prescribed. This medication error was not report to the prescriber. The Executive Director notified the MD and asked the MD to assess resident to see if ()*

188b Medication Error Reporting (continued)

needed any further treatment, no redness noted and no new orders were received.

2. On 5/21/26, all nurses and med techs were educated on compliance that while waiting for the pharmacy to enter new orders and until they are confirmed if the medication is in the facility administration is to be documented in a progress note in PCC and if medications are not available the prescriber needs notified.

3. Starting 6/8/26 the Resident Care Manager or designee will review the prior day's MARs for all residents to ensure compliance.

4. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.

5. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

190a - Completion Medication Course**27. 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 E was certified to pass medications on [REDACTED] but not recertified until [REDACTED]. Staff person E did not complete additional medication administration record (MAR) reviews or observations as required by the Department to make up for the missed annual recertification. The medication training completed on [REDACTED] was signed as complete by the medication administration trainer in January.

Plan of Correction

Accept () - 06/10/2026)

1. Upon notification from Surveyor that staff person E recertification was late, a plan was put in place to re educate staff person E.

2. On 5/15/26, the Resident Care Manager completed the Medication Course with staff person E again.

3. On 5/20/26 Executive Director and Resident Care Manager were educated on compliance with this regulation.

4. By 6/5/26, the Resident Care Manager will audit all current Med tech files for compliance.

5. Med tech observations have been entered on monthly calendars when due to ensure compliance.

5. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.

6. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

190b - Insulin Injections**28. Requirements**

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

190b - Insulin Injections (continued)**Description of Violation**

On 5/3/26 at 8:00 AM, staff person F, who hasn't passed the Department's medication training course, administered insulin to Resident #8.

Plan of Correction**Accept () - 06/10/2026)**

1. Upon notification from Surveyor that staff person G recertification was late, a plan was put in place to re-educate staff person G.
2. On 5/14/26, the Resident Care Manager completed the Medication Course with staff person E again.
3. On 5/20/26 Executive Director and Resident Care Manager were educated on compliance with this regulation.
4. All med tech Annual Diabetic Training are up to date.
5. By 6/5/26, the Resident Care Manager will audit all current Med tech files for compliance.
6. Med tech observations and Diabetic Trainings have been entered on monthly calendars when due to ensure compliance.
7. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
8. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026**Implemented () - 09/21/2026)****190c - Record of Training****29. Requirements**

2600.

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person E's 2025 annual training was altered with correction fluid over the date of completion and signatures by the trainer and student as well as the dates of completion for the fourth medication administration record (MAR) review and the passing or failing of the elements required for the fourth MAR review.

Plan of Correction**Accept () - 06/10/2026)**

1. Staff was notified by Surveyor that the medication administration training record for staff person E was altered with correction fluid.
2. On 5/20/26 Executive Director and Resident Care Manager were educated on compliance with this regulation, especially that correction fluid cannot be used in documentation, one line goes through an error with initials and date.
3. By 6/5/26, the Resident Care Manager will audit all current Med tech files for compliance.
4. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
5. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026**Implemented () - 09/21/2026)****225c - Additional Assessment**

30. Requirements

2600.

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

1. Annually.

Description of Violation

Resident #8's current assessment was completed [REDACTED], however, the resident's previous assessment was completed on [REDACTED]

Plan of Correction

Accept ([REDACTED]) - 06/10/2026)

1. The Surveyor notified the Executive Director that Resident #8 Annual assessment was completed three months late.
2. On 5/20/26 Executive Director, Resident Care Manager and Assistant Resident Care Manager were educated on compliance with this regulation
3. By 6/12/26 the Executive Director or designee will audit all current RASPs to ensure compliance.
4. Starting the week of 6/15/26, the Executive Director will review and initial all completed Annual RASPs to ensure compliance.
5. The Resident Care Manager will audit the DME/RASP Tracker Monthly to ensure compliance.
6. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
7. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented ([REDACTED]) - 09/21/2026)

233a - Lock Approval**31. Requirements**

2600.

233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health, or appropriate local building authority permitting the use of the new magnetic locking system that was installed on the secured dementia care unit egress doors in 2024.

Plan of Correction

Accept ([REDACTED]) - 06/10/2026)

1. On 5/12/26, the Campus Administrator notified NEPPS, the local lock company, the need for information regarding the Magnetic Lock/Egress Door System in use at the facility. The data sheet for the Stanley Delayed Egress Magnetic Lock System was received on 5/13/26 and given to the surveyor.
2. On 5/21/26, the Maintenance Director was educated on the compliance of this regulation.
3. The local fire chief was at the facility for inspection on 5/26/26 will provide written approval for the use of the magnetic locking system/egress doors on the Memory Care Unit.
4. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
5. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented ([REDACTED]) - 09/21/2026)

233b - Lock Manufacturer Statement

32. Requirements

2600.

233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:

1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The home does not have a statement from the manufacturer of the magnetic locking system installed on the egress doors of the secured dementia care unit that is specific to the home and that verifies that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

Plan of Correction

Accept () - 06/10/2026

1. On 5/12/26, the Campus Administrator notified NEPPS, the local lock company, the need for information regarding the Magnetic Lock/Egress Door System in use at the facility. The data sheet for the Stanley Delayed Egress Magnetic Lock System was received on 5/13/26 and given to the surveyor.
2. On 5/21/26, the Maintenance Director was educated on compliance of this regulation.
3. On 6/24/26, NEPPS, the local lock company will be at the facility to inspect the current magnetic locking system/egress doors on the Memory Care Unit and provide a written letter that the system is functioning properly.
4. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.
5. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026

236 - Staff Training

33. Requirements

2600.

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person D, who works in the Secured Dementia Care Unit (SDCU), had only received 2 hours of training in dementia care during the 2025 calendar training year.

Direct care staff person E, who works in the SDCU, had only 4 hours of training in dementia care during the 2025 calendar training year.

Plan of Correction

Accept () - 06/10/2026

1. The Surveyor notified the Executive Director the 2 staff persons did not receive their 6 hours of Annual Dementia training in 2025.
2. On 5/20/26, Executive Director, Resident Care Manager and Assistance Resident Care Manager were educated on compliance with this regulation.
3. On 5/21/26, all staff were educated on the requirement to complete 6 hours of annual Dementia training,

236 - Staff Training (continued)

education is be provided the 3rd Thursday of each month at the nursing meeting.

3. By 5/29/26, ancillary staff (maintenance and activities that transport residents) will be given packets of 3 hours of annual Dementia trainings to be completed by 6/30/26.

4. Starting 5/21/26, the Executive Director or designee will monitor attendance at each monthly nursing meeting and make sure the staff that do not attend the scheduled meeting complete the monthly training by the end of the month.

5. By 5/29/26 the Executive Director will complete an audit of current staff to make sure they have completed the 3 hours of Dementia training offered Jan through May 2026. Any missing educations will be completed by 6/30/26.

6. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.

7. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)

252 - Record Content**34. Requirements**

2600.

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

2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

Resident #6's record does not include the resident's eye color, race, and identifying marks, if any.

Repeated Violation - 9/10/24

Plan of Correction

Accept () - 06/10/2026)

1. Upon notification from the Surveyor the resident's face sheet was updated and the Admission Manager was educated on the information the is needed entered for each admission.

2. On 5/20/26, Executive Director, Resident Care Manager, Assistance Resident Care Manager and Admission Manager were educated on compliance with this regulation.

3. The week of 6/1/26, an audit of all resident charts will be completed and missing information will be updated by 6/30/26.

4. Starting the week of 6/8/26, The Executive Director or designee will review all new resident charts the day after admission using the Admission Manager Checklist to ensure and document compliance.

5. On 7/23/26, the compliance will be reviewed during the quarterly QA meeting.

6. All documentation will be kept.

Licensee's Proposed Overall Completion Date: 07/23/2026

Implemented () - 09/21/2026)