



Pennsylvania Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JULY 7, 2026

[REDACTED]
ER 320 OPERATIONS LLC
[REDACTED]
[REDACTED]

RE: Emerald Personal Care
320 Market Street
Elizabethtown, PA 17022
License/COC #: 338861

[REDACTED]:
As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on February 24, 2026, February 25, 2026, May 19, 2026 and May 20, 2026 of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby refuses to renew your certificate of compliance License #338860 dated August 8, 2025 to August 8, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (4); (5) and 55 Pa. Code §20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from JULY 7, 2026 to JANUARY 7, 2027.


All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
60(a)	II	21	\$5	\$105	5 calendar days From the date of This letter.
185(a)	II	21	\$5	\$105	5 calendar days From the date of This letter
190(a)	III	21	\$3	\$63	15 calendar days From the date of This letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

, Workload Manager
 Pennsylvania Department of Human Services
 Bureau of Human Services Licensing
 Forum Place, 6th Floor
 PO Box 2675
 Harrisburg, Pennsylvania 17105-2675

[REDACTED]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]

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

Facility Information

Name: EMERALD PERSONAL CARE License #: 33886 License Expiration: 08/08/2026
Address: 320 MARKET STREET, ELIZABETHTOWN, PA 17022
County: LANCASTER Region: CENTRAL

Administrator

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

Legal Entity

Name: ER 320 OPERATIONS LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C 1 Date: 05/20/1996 Issued By: Department of Health

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 22 Waking Staff: 17

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal, Complaint, Incident Exit Conference Date: 02/25/2026

Inspection Dates and Department Representative

02/24/2026 On Site: [REDACTED]
02/25/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 26 Residents Served: 22

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 6 Are 60 Years of Age or Older: 22
Diagnosed with Mental Illness: 4 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

02/24/2026 - Full

Lead Inspector: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 03/29/2026

04/03/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/13/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 04/10/2026

04/14/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/13/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission

Follow Up Date: 05/12/2026

06/23/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/13/2026

Reviewer: [REDACTED]

Follow Up Type: Enforcement

5a1 DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

- 1. Agents of the Department.

Description of Violation

On [redacted] at 9:05 AM, a staff list with staff titles and dates of hire was requested. The request was made again at 9:55 AM and at 10:25 AM. Staff Member A provided a staff list at 10:50 AM.

On [redacted] at 10:15 AM, the fire drill records and supervised fire drill letters from the local fire department were requested. These records and letters were not provided until [redacted] at 9:05 AM.

Plan of Correction

Directed [redacted] - 04/14/2026)

- 1) Administrator identified that HR staff failed to understand that requested information needs to be supplied in a timely manner. Maintenance Director is new to the facility and did not have required documents filed to provide in a timely manner.
- 2) HR Director to be educated on need to provide requested information in a timely manner. Maintenance Director to be educated on need to have required documents filed correctly to provide in timely manner.
- 3) NHA will complete survey ready book by 4/24/26 to include fire drills documentation and letter. Survey ready book will include list of current staff with titles and dates of hire.
- 4) Audits will be conducted by PCHA/ Designee monthly for 3 months to ensure required information is available and current in survey ready book. Audit will begin 4/14/26.

[Directed]

- In addition to the steps above, the Administrator or designee will educate the HR Director and the Maintenance Director on regulation 2600.5(a)1 no later than 5/12/26. Documentation of this education is to be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Implemented [redacted] - 06/23/2026)

17 Record Confidentiality

2. Requirements

2600.

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

Description of Violation

On [redacted] at 1:34 PM, the medical records office, containing all resident records, was unlocked, unattended, and accessible.

The pillow packs for the medications that have been administered to residents are disposed of in the "HIPPA" trash

17 Record Confidentiality (continued)

container affixed to the side of the first floor medication cart. This trash container has a rectangular opening cut out at the top with no cover. On [REDACTED] at 11:21 AM, these pillow packs were visible in the trash container and contained information such as the resident's name, the name of the medication(s) that had been in the pillow packs, the medication dosages and the RX numbers. Resident [REDACTED]'s pillow pack for [REDACTED] prescribed Mag 64 tablet was visible at the top of the pile of pillow packs. According to Staff Member B, this trash is emptied about once a month by taking the empty bags to the shredding area. This box is frequently open, unattended and accessible except when medications are being administered.

Repeated Violation [REDACTED], et al

Plan of Correction

Accept [REDACTED] 04/14/2026)

- 1) Pillow packs were immediately disposed of by the PC director in a HIPAA compliant container.
- 2) PHCA/Designee will educate Medtech by 4/14/26 that no resident health information can be visible at any time. Resident pillow packs must be disposed of in a HIPAA complaint container. MedTech must secure resident records including keeping medical office locked when unattended.
- 3) Audits will be conducted by PCHA/ Designee monthly for 3 months to ensure bins are emptied daily and that medical office is locked when not unattended. Audit will begin on 4/16/26

Licensee's Proposed Overall Completion Date: 04/24/2026

Not Implemented ([REDACTED] - 06/23/2026)

60a - Staff/Support Plan

3. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

From [REDACTED] through [REDACTED] during the overnight shift from 10:00 PM through 6:00 AM, there were no staff who were certified with the department approved medication administration training. As a result, the home was unable to provide medication administration services to residents who are prescribed medications on an as needed basis during this time. There are several residents who are prescribed PRN medications including:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

Repeated Violation [REDACTED], et al

60a Staff/Support Plan (continued)

Plan of Correction

Directed () - 04/14/2026)

- 1) PCHA identified that there was no tracking plan in place to ensure staff obtain their medication administration certificates.
- 2) Initial audit of Current Personal Care Home employee files was completed on 2/25/26 by PCHA/ Designee to ensure staff certificates are present in file
- 3) Human Resources Director and Personal Care Home Coordinator will be educated by the PCHA/ Designee on the importance of employees obtaining their medication administration to certification prior to hire and annually as required by 4/14/2026.
- 4) Biweekly audits starting 4/20/2026 will be conducted by PCHA/ Designee on PC Schedules for 2 months to ensure there is Medication Administration Certified Medtech on site for each shift.

[Directed]

- In addition to the steps above, the Administrator or designee will complete an initial audit of all current med techs medication administration certifications to ensure all current med techs are up to date with their medication administration certifications. This will be completed by 5/12/26. Documentation of this audit will be kept and available for review by the Department.
- The Administrator or designee will educate HR Director and Personal Care Home Coordinator on needing to have a med tech available on all shifts due to PRN medications being prescribed. This will be completed by 5/12/26. Documentation of this education will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Not Implemented () 06/23/2026)

63a - First Aid/CPR Training

4. Requirements

2600.

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

Description of Violation

From () at 10:00 AM until () at 6:00 AM, there were 22 residents present in the home. However, during this time there were no staff present in the home who were certified in both CPR and First Aid.

From () at 2:00 PM until () at 6:00 AM, there were 22 residents present in the home. However, during this time there were no staff present in the home who were certified in both CPR and First Aid.

From () at 10:00 PM until () at 6:00 AM, there were 22 residents present in the home. However, during this time there were no staff present in the home who were certified in both CPR and First Aid.

From () at 10:00 PM until () at 6:00 AM, there were 22 residents present in the home. However, during this time there were no staff present in the home who were certified in both CPR and First Aid.

Repeated Violation (), et al

63a - First Aid/CPR Training (*continued*)**Plan of Correction****Directed** [REDACTED] - 04/14/2026)

- 1) Medtech staff will complete the CPR/AED/First Aid training by 4/15/2026
- 2) Personal Care Home employee files reviewed by PCHA/ Designee to ensure staff certificates are present in file
- 3) Human Resources Director and Personal Care Home Coordinator educated by the PCHA/ Designee on the importance of each new hire employee obtaining their CPR/First Aid certification prior to hire to complete the onboarding process as required by the Department
- 4) Monthly audits will be conducted by PCHA/ Designee on employee files for 3 months to ensure compliance

[Directed]

- In addition to the steps above, the Administrator or designee will complete an initial audit of all current staff files for current First Aid and CPR Certifications. This will be completed by 5/12/26. Documentation of this audit will be kept and available for review by the Department.
- The Administrator or designee will educate HR Director and Personal Care Home Coordinator on regulation 2600.63(a). This will be completed by 5/12/26. Documentation of this education will be kept and available for review by the Department.
- Beginning no later than 5/12/26, the Administrator or designee will audit the work schedules prior to the schedules being posted to ensure there are the required number of staff First Aid and CPR certified based on the resident census for each shift. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026**Implemented** [REDACTED] - 06/23/2026)

65a - FS Orientation 1st Day

5. 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 Member D, hired on [REDACTED], did not receive orientation on the following topics:

- Evacuation procedures.
- Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
- Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- The location and use of fire extinguishers.

65a FS Orientation 1st Day (continued)

- Smoke detectors and fire alarms.
- Telephone use and notification of emergency services.

Plan of Correction

Directed [REDACTED] - 04/14/2026)

- 1) Staff member D will complete orientation education by 4/14/26.
- 2) PCHA/Designee conducted an audit on 3/24/26 ensure no other staff did not receive orientation
- 3) PCHA will educate HR Director by 4/14/26 that PC staff are required to have completed orientation education prior to starting on the floor.
- 4) Monthly audits for 3 months starting on 4/20/2026 will be conducted by PCHA/designee for all new staff to ensure they are being completed.

[Directed]

- In addition to the steps above, the Administrator or designee will educate HR Director on regulation 2600.65(a), including this orientation needs to occur on the new employees first day of work. This will be completed by 5/12/26. Documentation of this education will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Not Implemented [REDACTED] 06/23/2026)

65b - Rights/Abuse 40 Hours

6. Requirements

2600.

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

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Member D, completed [REDACTED] 40th scheduled work hour by [REDACTED]. However, Staff Member D did not complete training in the following topics:

- Resident rights.
- Emergency medical plan.
- Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
- Reporting of reportable incidents and conditions.

Plan of Correction

Directed [REDACTED] - 04/14/2026)

- 1) Facility identified that Staff member didn't have an orientation education filled out
- 2) HR conducted an audit ensure no other staff did not receive education on abuse, resident rights, emergency plan

65b Rights/Abuse 40 Hours (continued)

and provide those staff with an orientation by 4/17/2026

3) PCHA will educate HR Director by 4/14/26 that PC staff are required to have completed orientation education during their first 40 hours.

4) Monthly audits starting on 4/20/2026 for 3 months will be conducted by PCHA or designee to ensure all new staff have orientation completed timely.

[Directed]

- In addition to the steps above, the Administrator or designee will educate Staff Member D on the orientation topics for 65(b) by 5/12/26. Documentation of this education will be kept and available for review by the Department.
- The Administrator or designee will conduct an initial audit of all current staff records to identify if any other staff have not received orientation on the required topics within the first 40 hours worked. This will be completed by 5/12/26. Documentation of this audit will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Not Implemented [redacted] - 06/23/2026)

65g - Annual Training Content

7. Requirements

2600.

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff Member B, hired on [redacted], Staff Member D, hired on [redacted], and Staff Member E, hired on [redacted] did not receive the following training during the 2025 training year:

- Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Repeated Violation [redacted], et al

Plan of Correction

Accept [redacted] 04/14/2026)

1. PCHA will educate PC Director and HR and medtech staff by 4/14/2026 on the importance of participating and completing annual fire safety training.
2. Audited and identified other staff that required training from a fire safety expert on 2/24/26.
3. Representative that is trained by a fire safety expert will conduct a training by 4/19/2026
4. Monthly audits starting on 4/20/2026 for 3 months will be conducted by PCHA or designee to review the staff training will be conducted to ensure compliance is maintained moving forward starting

Licensee's Proposed Overall Completion Date: 05/01/2026

65g Annual Training Content (continued)

Not Implemented [redacted] - 06/23/2026)

65i Training Record

8. Requirements

2600.

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

Description of Violation

During an interview with Staff Member F, hired on [redacted], they confirmed they had been educated in the following areas when they started working in the home:

- Evacuation procedures.
- Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
- Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- The location and use of fire extinguishers.
- Smoke detectors and fire alarms.
- Telephone use and notification of emergency services.
- Resident rights.
- Emergency medical plan.
- Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101 —10225.5102).
- Reporting of reportable incidents and conditions.

However, the home has no documentation showing Staff Member F received these trainings.

Plan of Correction

Directed [redacted] - 04/14/2026)

- 1) Facility identified that staff didn't have documentation of training in staff file,
- 2) HR will conducte an audit to ensure other PC staff have orientation and provide missing members an orientation by 4/16/2026.
- 3) PCHA will educate HR director the need to maintain staff files
- 4) Monthly audits starting on 4/20/2026 for 3 months will be conducted by PCHA or designee to ensure documentation of training are in staff files

[Directed]

- In addition to the steps above, the Administrator or designee will educate HR Director on regulation 2600.65(i). This will be completed by 5/12/26. Documentation of this education will be kept and available for review by the Department.
- The Administrator or designee will document the situation and violation in Staff Member F's record no later than 5/12/26.

Directed Completion Date: 05/12/2026

Not Implemented [redacted] 06/23/2026)

85a - Sanitary Conditions

9. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted] at 4:30 PM, Resident [redacted]'s glucometer was used to take Resident [redacted] blood sugar reading.

Plan of Correction

Accept [redacted] - 04/14/2026)

- 1) Facility identified that residents [redacted] glucometers was used for resident [redacted] facility ensured more glucometers used so each resident who needs has their own by 4/14/2026
- 2) PCHA/ designee will educate Medtechs staff on not sharing glucometer by 4/14/2026
- 3) PCHA/ designee will audits for 3 months starting on 4/20/2026 to ensure each resident's glucometer readings with the MAR readings to ensure the correct glucometer is being used on the correct resident

Licensee's Proposed Overall Completion Date: 04/24/2026

Implemented [redacted] - 06/23/2026)

85e - Trash Outside Home

10. Requirements

2600.

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

Description of Violation

On [redacted] at 8:50 AM, one of the two outside dumpsters had its top lid open, and the second dumpster had its side door open. Both dumpsters were filled with trash.

Plan of Correction

Accept [redacted] - 04/14/2026)

- 1) Facility ensured that both Dumpster bin were closed on 2/25/2025 by Director of Food service
- 2) PCHA/ designee will educate staff on the importance of closing the dumpster bin after use by 4/14/2026
- 3) Director of Food service / designee will audit weekly for 2 months starting on 4/20/2026 to ensure the bins are closed after use

Licensee's Proposed Overall Completion Date: 04/24/2026

Implemented [redacted] 06/23/2026)

86b - Bathroom

11. Requirements

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On [REDACTED], the bathroom in resident room [REDACTED] resident room [REDACTED] and resident room [REDACTED] did not have an operable window or ventilation fan. The fans were inoperable, and there was no window in the bathrooms.

Plan of Correction

Accept [REDACTED] - 04/14/2026)

- 1) Facility identified the vent fans not operational.
- 2) Maintenance director or designee will conduct and audit for other bathrooms without a window to ensure they have an operational vent fan and have a completion date of 4/30/2026
- 3) PCHA/ designee will educate Medtechs and Maintenance staff by 4/14/2026 on the importance of having a vent fan or window in resident bathroom and to inform maintenance of any issues.
- 4) PCHA/ designee will audits for 3 months starting on 5/1/2026 to ensure bathrooms have a window present or that vent fans are operational.

Licensee's Proposed Overall Completion Date: 05/01/2026

Not Implemented [REDACTED] - 06/23/2026)

87 Lighting

12. Requirements

2600.

87. Lighting The home's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On [REDACTED] at approximately 9:45 AM, the light fixture in the main hallway located outside of resident room [REDACTED] was out. Staff Member B reported the light has been out since a car drove into a pole outside of the home approximately 2 weeks prior.

Plan of Correction

Accept [REDACTED] - 04/14/2026)

- 1) Staff identified that the light was out
- 2) Maintenance/ designee checked for any other lighting in resident areas that are out to be ordered on and installed parts on 4/10/2026
- 3) PCHA/ designee will educate Medtechs and maintenance by 4/14/2026 on the importance of lights working and informing Maintenance
- 4) PCHA/ designee will audits for 3 months starting on 4/20/2026 to ensure that lighting for the entire PC are operational

Proposed Overall Completion Date: 04/24/2026

Licensee's Proposed Overall Completion Date: 04/24/2026

Implemented [REDACTED] - 06/23/2026)

88a Surfaces

13. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On [redacted] at approximately 9:35 AM, there were large water stains on the ceiling tiles near the elevator located in front of the medical office.

On [redacted] at approximately 9:40 AM, there was a drywall bulkhead with flaking and crumbling drywall located in the hallway by the laundry room on the second floor.

On [redacted] at approximately 9:40 AM, there is a damaged windowsill with flaking paint from water damage located by the upstairs medication cart.

On [redacted] at approximately 9:43 AM, there were heavily damaged, water-stained ceiling tiles located in the dining room.

On [redacted] at 9:47 AM, there was a heavily damaged, water-stained ceiling tile located in the personal care hall at the entrance to the kitchen. The stain was approximately 2 feet by 2 feet. In the center of the water stain, there was a black mold spot, measuring approximately 6 inches.

Plan of Correction

Accept [redacted] - 04/14/2026)

- 1) Facility staff identified areas of repair
- 2) Maintenance director will audit resident areas and will schedule repair work in affected areas with a completion date of 4/30/2026
- 3) PCHA/ designee will educate Medtechs and maintenance by 4/14/2026 on the importance of facility to be in good repair
- 4) PCHA/ designee will audits for 3 months starting on 5/1/2026 to ensure facility is in good repair.

Licensee's Proposed Overall Completion Date: 05/01/2026

Not Implemented [redacted] - 06/23/2026)

92 Windows

14. Requirements

2600.

92. Windows and Screens Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On [redacted] at approximately 9:42 AM, the window in the dining room did not open or close easily and was crooked in the frame.

On [redacted] at 11:30 AM, the window in resident room [redacted] was open and had no screen.

Plan of Correction

Accept [redacted] - 04/14/2026)

- 1) Maintenance director was made aware of window crooked it frame and immediately but it back on track on 2/24/2026.
- 2) Maintenance director identified window open in room 29 and closed the window 2/26/2026
- 3) Maintenance director/ designee will audit windows to ensue they are closed and in the track

92 - Windows (continued)

- 4) PCHA/ designee will educate Medtechs and maintenance by 4/14/2026 on the importance windows be closed and, in their track, and inform maintenance
- 5) PCHA/ designee will audits for 3 months starting on 4/20/2026 to ensure facility windows are in good repair

Licensee's Proposed Overall Completion Date: 04/24/2026

Implemented [redacted] - 06/23/2026)

95 - Furniture and Equipment

15. Requirements

2600.

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

Description of Violation

The door to the shower in resident room [redacted] was difficult to close, requiring upward pressure and slamming it in order to shut.

On [redacted] one of the commercial washers located in the main laundry room on the first floor was inoperable. The washer had steaming hot water inside, causing condensation on the washer which then caused the air in the laundry room to be humid. It also caused water droplets to form on the ceiling tiles, tracks, and metal vents in the room.

On [redacted] a loveseat in the upstairs lounge seat had peeling vinyl covering.

On [redacted] the toilet in the bathroom of resident room [redacted] was not secure to the floor and shifts with slight pressure.

Plan of Correction

Directed [redacted] - 04/14/2026)

- 1) Facility identified Furniture and Equipment that needed repair
- 2) Maintenance director will audit facility to ensure Furniture and Equipment are functioning properly by 4/14/2026.
- 3) Toilet in room 29 was repaired by 4/1/2026, Commercial washer was fixed and by 3/15/2026, love seat removed
- 4) Room 17 shower door will be scheduled to be completed by 4/30/2026
- 5) PCHA/ designee will audits for 3 months starting on 5/1/2026 to ensure facility is in good repair

[Directed]

- In addition to the steps above, the Administrator or designee will educate the Maintenance Director and maintenance staff on regulation 2600.95 by 5/12/26. Documentation of this education will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Implemented [redacted] - 06/23/2026)

101o - Walls, Floors, Ceilings

16. Requirements

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

101o - Walls, Floors, Ceilings (continued)

Description of Violation

On [redacted] at 2:27 PM, the ceiling over the bathtub in resident room [redacted] was unfinished and in poor repair. The drywall was rough and unsanded. The compound and drywall tape was also sagging, posing a collapsing risk.

The ceiling in Resident [redacted] room had large water stains on the corner above the recliner.

The laminated wood door of the bathroom in resident room [redacted] had three large missing areas where the laminate has peeled away from the door. These missing areas ran from the top to the bottom of the door.

The green wall in resident room [redacted] had various shades of green paint which have been painted over crumbling plaster. There was also a dark stain, measuring approximately 15 inches by 15 inches, located on the floor.

Plan of Correction

Directed [redacted] - 04/14/2026)

- 1) Facility identified Furniture and Equipment that needed repair
- 2) Maintenance director will audit resident rooms to ensure walls, floors and ceiling are in good condition by 4/14/2026.
- 3) Maintenance director will create a job tasks to be completed my Maintenance director or designee by 4/30/2026
- 4) PCHA/ designee will audits for 3 months starting on 5/1/2026 to ensure walls, floors, ceiling are In good repair.

[Directed]

- In addition to the steps above, the Administrator or designee will educate the Maintenance Director and maintenance staff on regulation 2600.101(o) by 5/12/26. Documentation of this education will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Not Implemented [redacted] 06/23/2026)

121a - Unobstructed Egress

17. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On [redacted] at 9:51 AM, a milk crate was upside down behind the back exit door on the lower level, which caused the door to not open fully.

Plan of Correction

Accept [redacted] 04/14/2026)

- 1) Identified obstructed egress
- 2) PCHA immediately removed items for egress exit
- 3) PCHA/ designee will educated staff on the requirements to not have obstructed exits by 4/14/2026
- 4) PCHA/ designee will audits for 3 months starting on 4/20/2026 to ensure egress are unlocked and unobstructed.

121a - Unobstructed Egress (continued)

Licensee's Proposed Overall Completion Date: 04/24/2026

Implemented [REDACTED] - 06/23/2026)

132a - Monthly Fire Drill

18. Requirements

2600.

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

Description of Violation

An unannounced fire drill was not held during the months of July, August, November and December of 2025 as well as January of 2026.

Repeated Violation - [REDACTED], et al

Plan of Correction

Accept [REDACTED] - 04/14/2026)

- 1. Deficiency unable to be retroactively corrected.
- 2. All monthly drills will be unannounced and will be recorded to track for completion and will be monitored by the Director of Maintenance and then reported to the Personal Care Administrator for completion and compliance.
- 3. Personal Care Administrator provided training to Maintenance Director on 3/26/2026 regarding facilities fire drill protocol/procedure and the importance of maintaining a monthly fire drill schedule.
- 4. PCHA/ designee will monitor monthly for 3 months the monthly drill reporting logs and include tracking data in the monthly log starting on 4/20/2026.

Licensee's Proposed Overall Completion Date: 04/24/2026

Implemented [REDACTED] - 06/23/2026)

132c - Fire Drill Records

19. Requirements

2600.

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

Description of Violation

The fire drill record for the drill conducted on [REDACTED] at 7:45 AM indicates a total of 57 residents were in the home at the time of the drill. However, the home is only licensed for 26 residents.

The fire drill record for the drill conducted on [REDACTED] at 6:15 AM indicates a total of 57 residents were in the home at the time of the drill. However, the home is only licensed for 26 residents. The record also indicates no residents were evacuated during the drill; however, the fire drill record did not include any problems occurred.

The fire drill record for the drill conducted on [REDACTED] at 6:45 AM indicates a total of 12 residents were in the home at the time of the drill. However, no residents were evacuated during the drill, but the record indicates there were no problems during this drill.

132c Fire Drill Records (continued)

The fire drill record for the drill conducted on [REDACTED] at 1:00 PM does not include the total number of residents who evacuated, the exit routes used, whether the fire alarm was operable and whether any problems occurred.

Plan of Correction

Accept [REDACTED] - 04/14/2026)

1. Deficiency unable to be retroactively corrected.
2. All monthly drills recorded to track for completion and will be monitored by the Director of Maintenance and then reported to the Personal Care Administrator for completion and compliance.
3. Personal Care Administrator provided training to Maintenance Director on 3/26/2026 regarding facilities fire drill protocol/procedure and the importance of maintaining accurate records for the monthly drill and using the correct tracking fire drill log.
4. PCHA/ designee will monitor monthly for 3 months the monthly drill reporting logs and reviewing the actual fire drill documentation for completeness starting on 4/20/2026.

Licensee's Proposed Overall Completion Date: 04/24/2026

Implemented [REDACTED] - 06/23/2026)

132h - Designated Meeting Place

20. Requirements

2600.

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

Description of Violation

The fire drill record for the drill conducted on [REDACTED] at 7:45 AM states that a total of 57 residents were in the home. However, the home is only licensed for 26 residents. None of the residents were evacuated during the drill.

The fire drill record for the drill conducted on [REDACTED] at 6:15 AM indicates a total of 57 residents were in the home at the time of the drill. However, the home is only licensed for 26 residents. None of the residents were evacuated during the drill.

During the fire drill on [REDACTED] at 6:45 AM, there were 12 residents in the home at the time of the drill. However, none of the residents evacuated during the drill.

Repeated Violation [REDACTED] et al

Plan of Correction

Directed [REDACTED] - 04/14/2026)

1. PCHA/ designee will provide training/education to Personal Care Home residents and staff that residents are to evacuate the building to the established meeting place away from the building or within a fire safe area during a fire drill or actual emergency.
2. Monthly drill will be conducted and recorded by the Maintenance director to track for completion and then reported to the Personal Care Administrator for completion and compliance.

132h Designated Meeting Place (continued)

3. PCHA/ designee will audit monthly fire drill reporting starting 4/20/2026 to ensure residents and staff go to the designated fire safe area.

[Directed]

- In addition to the steps above, the Administrator or designee will educate all staff and residents regulation 2600.132(h) by 5/12/26. Documentation of this education will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Not Implemented (████ - 06/23/2026)

141a - Medical Evaluation

21. Requirements

2600.

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

Description of Violation

Resident █████ initial medical evaluation, dated █████ does not indicate if the resident's needs can be met in the personal care home.

Resident █████ initial medical evaluation, dated █████ does not indicate if the resident's needs can be met in the personal care home.

Plan of Correction

Directed █████ 04/14/2026)

- 1) Facility made aware of proper medical evacuation procedures and PC director/designee will audit all residents to ensure they have the correct medical evacuations and contact the physician if needed by 4/16/2026
- 2) PCHA/designee will educate Medtechs by 4/16/2024 on the proper documentation needed from the physician to ensure that facility can meet the needs of the residents
- 3) PCHA/designee will review the initial medical evaluations for new residents for 3 months to ensure that residents needs came be met starting on 4/20/2026.

[Directed]

- In addition to the steps above, the Administrator or designee will educate all med techs on regulation 2600.141(a) regarding initial medical evaluations need to be filled out completely including identifying a resident's needs can be met in a personal care home by 5/12/26. Documentation of this education will be kept and available for review by the Department.
- The Administrator or designee will complete an initial audit of all current residents' initial medical evaluations for completeness and address any missing information found. This will be completed by 5/12/26. Documentation of this audit will be kept.

141a Medical Evaluation (continued)

- The Administrator or designee will update Resident [REDACTED] and Resident [REDACTED]'s initial medical evaluations by 5/12/26.
- Beginning no later than 5/12/26, the Administrator or designee will review initial medical evaluations for new residents to ensure completeness. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Not Implemented [REDACTED] - 06/23/2026)

141b1 - Annual Medical Evaluation

22. Requirements

2600.

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

Description of Violation

Resident [REDACTED]'s current annual medical evaluation, dated [REDACTED] does not indicate if the resident's needs can be met in the personal care home.

Plan of Correction

Directed [REDACTED] - 04/14/2026)

- 1) Facility made aware of proper annual medical evacuation procedures and PC director/designee will audit all residents to ensure they have the correct medical evacuations and contact the physician if needed by 4/16/2026
- 2) PCHA/designee will educate Medtechs by 4/16/2024 on the proper documentation needed from the physician annually to ensure that facility can meet the needs of the residents
- 3) PCHA/designee will audit current resident annual/significant change medical evaluations for 3 months all residents to ensure that residents needs came be met starting on 4/20/2026.

[Directed]

- In addition to the steps above, the Administrator or designee will educate all med techs on regulation 2600.141(b) regarding annual and significant change medical evaluations need to be filled out completely including identifying a resident's needs can be met in a personal care home by 5/12/26. Documentation of this education will be kept and available for review by the Department.
- The Administrator or designee will complete an initial audit of all current residents' annual and significant change medical evaluations for completeness and address any missing information found. This will be completed by 5/12/26. Documentation of this audit will be kept.
- The Administrator or designee will update Resident [REDACTED]'s current annual medical evaluation by 5/12/26.
- Beginning no later than 5/12/26, the Administrator or designee will review all current annual and significant change medical evaluations to ensure completeness. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Not Implemented [REDACTED] - 06/23/2026)

144c1 - Smoking Area Guidelines

23. Requirements

2600.

144c1 Smoking Area Guidelines (continued)

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home does not have a designated smoking area and has a no smoking on the property policy. On [redacted] at 9:39 AM, there was an unsmoked cigarette on the floor of the covered porch located on the second floor. On [redacted] at approximately 9:45 AM, the exit at the end of the hallway to the rear of the home was opened. In the alcove, was a makeshift smoking area with a cardboard box full of cigarette butts. On [redacted] and [redacted] there were a large amount of cigarette butts located on the ground at the back of the home, at the front entrance of the home and at other entrances to the home.

Plan of Correction

Accept ([redacted] - 04/14/2026)

- 1) Facility grounds cleared of cigarette butts by housekeeping staff/designee by 3/20/2026
- 2) Residents and staff educated on smoking location by PCHA/ designee by 4/14/2026
- 3) PCHA/ designee will audit for 3 months starting 4/20/2026 to ensure that staff and residents are following protocols and the grounds are clear of cigarette butts.

Licensee's Proposed Overall Completion Date: 04/24/2026

Not Implemented ([redacted] - 06/23/2026)

183b - Meds and Syringes Locked

25. 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 [REDACTED] at 2:00 PM, a bottle of [REDACTED] was in Resident [REDACTED]'s room. However, Resident [REDACTED]'s room was unlocked, unattended and accessible.

On [REDACTED] at approximately 11:34 AM, a bottle of [REDACTED] was in Resident [REDACTED]'s room. However, Resident [REDACTED]'s room was unlocked, unattended and accessible.

Plan of Correction

Accept ([REDACTED]) - 04/14/2026

- 1) Facility made aware of medicated power in residents room that was not locked, medication was given to the PC director and secured on 2/24/26 and 2/25/26
- 2) PCHA/designee educated Medtech staff by 4/14/2026 that medications must be locked in a container or removed
- 3) PCHA/designee will audit resident rooms for 3 months starting 4/20/2026 to ensure medications are locked in a container.

Licensee's Proposed Overall Completion Date: 04/24/2026

Not Implemented ([REDACTED]) - 06/23/2026

184a - Resident's Meds Labeled

26. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] tablet with orders to take one tablet by mouth once daily for [REDACTED]. However, the medication bottle for this medication did not have a pharmacy label.

Plan of Correction

Directed ([REDACTED] - 04/14/2026)

- 1) Facility made aware that medication didn't have a label with the required info, PC director added the required resident info on medication on 2/25/2026
- 2) PCHA/ designee will educate Medtech staff by 4/14/2026 that all medications must have the Pharmacy label with the name of resident, medication, issued date, dosage, provider on medication container.
- 3) PCHA/ designee will audits for 3 months starting 4/20/2026 will be conducted to ensure medications have proper label information on container

[Directed]

- In addition to the steps above, the Administrator or designee will obtain a new pharmacy label for Resident [REDACTED] s prescribed [REDACTED] by 5/12/26.

Directed Completion Date: 05/12/2026

Not Implemented ([REDACTED] - 06/23/2026)

185a - Implement Storage Procedures

27. 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

The following discrepancies were found between the blood sugar readings in Resident [REDACTED] s glucometer and the documented blood sugar readings documented in Resident [REDACTED] s medication administration record (MAR):

- [REDACTED]
- [REDACTED]
- [REDACTED]

The following discrepancies were found between the blood sugar readings in Resident [REDACTED] s glucometer and the

185a - Implement Storage Procedures (continued)

documented blood sugar readings documented in Resident [REDACTED]'s MAR:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

Resident [REDACTED] is prescribed [REDACTED] as needed for indigestion. However, on 2/25/26, this medication was not available in the home.

Repeated Violation [REDACTED], et al

Plan of Correction

Directed ([REDACTED] - 04/14/2026)

- 1) Facility made aware of discrepancy in documentation
- 2) PC director/ designee will audit PRN medications to ensure facility has these medications onsite by 4/14/2026
- 3) PCHA/ Designee will educate Medtech by 4/14/2026 that the reading in the residents' glucometers must match what's documented on their MARs and PRN medication needs to be available on-site.
- 4) PCHA/ Designee will audit for 3 months starting 4/20/2026 to ensure residents' glucometers match what's documented on their MARs and PRN medication are available on site

[Directed]

- In addition to the steps above, the Administrator or designee will order and ensure Resident [REDACTED]'s prescribed Calcium Carbonate is on-site by 5/12/26.

Directed Completion Date: 05/12/2026

Not Implemented ([REDACTED] - 06/23/2026)

187b - Date/Time of Medication Admin.

28. 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 [REDACTED] is prescribed [REDACTED] with orders to take one capsule by mouth once weekly. Resident [REDACTED]'s February 2025 medication administration record (MAR) does not include the initials of the staff person who administered this medication on [REDACTED] at 8:00 AM and on [REDACTED] at 8:00 AM.

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

Resident [redacted] is prescribed [redacted] with orders to test twice daily at 6:30 AM and 4:30 PM. Resident [redacted] s February 2025 MAR does not include the initials of the staff person who performed blood sugar testing on [redacted] at 4:30 PM.

Resident [redacted] is prescribed [redacted] with orders to take one tablet by mouth twice daily at 6:30 AM and 4:30 PM. Resident [redacted] s February MAR does not include the initials of the staff person who administered this medication on [redacted] at 6:30 AM.

Plan of Correction

Directed ([redacted] - 04/14/2026)

- Facility made aware of missing staff signing off on the MAR and can not retroactively correct this
- 2) PCHA/ Designee educated Medtech staff by 4/14/2026 on the importance of proper documentation on the MAR.
- 3) PCHA/ Designee will audit resident MARs for 3 months starting 4/20/2026 to ensure documentation on the MAR is being recorded properly.

[Directed]

- In addition to the steps above, the Administrator or designee will document error in the identified MARs for Resident [redacted] Resident [redacted] and Resident [redacted]. This will be completed by 5/12/26.
- Beginning no later than 5/12/26, the Administrator or designee will audit all current resident MARs monthly for 3 months. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Not Implemented ([redacted] - 06/23/2026)

187c - Refusal of Medication

29. Requirements

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

At 7:00 AM on [redacted] and [redacted] Resident [redacted] refused to take the scheduled dose of [redacted] prescribed [redacted]. However, the home did not notify the resident's prescriber of these refusals.

At 7:00 AM on [redacted] and from [redacted], Resident [redacted] refused to take the scheduled dose of [redacted] prescribed [redacted]. However, the home did not notify the resident's prescriber of these refusals.

Plan of Correction

Directed ([redacted] - 04/14/2026)

- 1) PC director/ designee audited the MAR to see if any additional residents refused medication and notified the

187c - Refusal of Medication (continued)

provider/ followed the providers instruction by 4/14/2026.

2) PCHA/ designee educated Medtech by 4/14/2026 on the importance of notification to the provider of a refusal within 24 hours and documentation needs to be kept if resident refused a medication.

3) PCHA/ designee will audit resident MAR for 3 months starting 4/20/2026 to ensure that staff are notifying the provider if medication is refused within the proper time.

[Directed]

- In addition to the steps above, the Administrator or designee will notify Resident [REDACTED]'s prescriber of . This will be completed by 5/12/26.

Beginning no later than 5/12/26, the Administrator or designee will audit all current resident MARs monthly for 3 months. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Not Implemented ([REDACTED] - 06/23/2026)

190a - Completion Medication Course**30. 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 Member B completed the modified medication administration training, not the required standard medication administration training. Staff Member B administered medications the following residents:

- [REDACTED]
- [REDACTED]
- [REDACTED]

Staff Member C, whose initial standard medication administration training was completed on [REDACTED] did not have an annual practicum form completed for 2025. Staff Member C administered medications the following residents:

- [REDACTED]
- [REDACTED]
- [REDACTED]

Staff Member E completed the modified medication administration training, not the required standard medication administration training. Staff Member E administered medications the following residents:

- [REDACTED]
- [REDACTED]
- [REDACTED]

Repeated Violation - [REDACTED] et al

Plan of Correction

Directed [REDACTED] 04/14/2026)

1. HR/ designee will conduct an initial audit on all medtech staff records to ensure that all employees have completed an approved Medication Administration Course as well as any annual practicum that is required by the

190a - Completion Medication Course (continued)

Department by 4/14/2026. All employees found not to be in compliance will receive the required training from an certified train the Trainer with an anticipated start date of 4/27/2026.

2. The Train the Trainer Course will be initiated with an anticipated start date of 4/20/2026.

3. PCHA/ Designee will educate the medtechs, HR and the PC director on the proper medication administration training and annual practicum requirements set forth by the Department by 4/14/2026.

4. Monthly audits will be conducted by PCHA/ Designee on employee files to ensure Medtechs have the required trainings quarterly to ensure compliance starting on 5/1/2026

[Directed]

- In addition to the above steps, the Administrator or designee will ensure Staff Members B, C and E complete the Standard Medication Administration Course and all initial medication administration requirements 5/12/26. Certifications and documentation of completed initial requirements will be kept and available for review by the Department.
- HR or designee will complete an initial audit of all current med techs medication administration certification as well as initial and annual practicum forms to ensure compliance. Any med tech out of compliance will either complete the Standard Medication Administration Course and all initial medication administration requirements or complete required remediation, if applicable. This will be completed by 5/12/26. Any issues found will be remedied by 5/12/26. Documentation of this audit will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Not Implemented ([REDACTED] - 06/23/2026)

190b - Insulin Injections

31. 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.

Description of Violation

Staff Member B completed the modified medication administration training, not the required standard medication administration training. Also, Staff Member B's last diabetic education was completed on [REDACTED] Staff Member B administered insulin to the following residents:

- [REDACTED]
- [REDACTED]

Staff Member C, whose initial standard medication administration training was completed on [REDACTED], did not have an annual practicum form completed for 2025. Also, Staff Member C's last diabetic education was completed on [REDACTED] Staff Member C administered insulin to the following residents:

- [REDACTED]
- [REDACTED]

Staff Member E completed the modified medication administration training, not the required standard medication administration training. Staff Member E administered insulin to the following residents:

- [REDACTED]

190b Insulin Injections (continued)

- [REDACTED]

Plan of Correction

Directed ([REDACTED]) - 04/14/2026

1. HR/ designee will conduct an initial audit by 4/14/2026 on all medtech staff records to ensure that all employees have completed an approved Medication Administration Course and diabetic training as well as any annual practicum that is required by the Department. All employees found not to be in compliance will receive the required training from an certified trainer with an anticipated start date of 4/27/2026.
2. PCHA/ Designee will educate the medtechs, HR and the PC director on the proper medication administration training and annual practicum requirements set forth by the Department by 4/14/2026.
4. Monthly audits will be conducted by PCHA/ Designee on employee files to ensure Medtechs have the required trainings quarterly to ensure compliance starting on 5/1/2026

[Directed]

- In addition to the above steps, the Administrator or designee will ensure Staff Members B, C and E complete the Standard Medication Administration Course and all initial medication administration requirements by 5/12/26. Certifications and documentation of completed initial requirements will be kept and available for review by the Department.
- HR or designee will complete an initial audit of all current med techs medication administration certification, initial and annual practicum forms and diabetic training to ensure compliance. Any med tech out of compliance will either complete the Standard Medication Administration Course and all initial medication administration requirements, complete required remediation, if applicable, or receive diabetic training depending on the reason(s) for the med tech(s) being out of compliance. This will be completed by 5/12/26. Any issues found will be remedied by 5/12/26. Documentation of this audit will be kept and available for review by the Department.
- The Administrator or designee will educate the med techs, HR and PC Director on regulation 2600.190(b) by 5/12/26. Documentation of this education will be kept and available for review by the Department.

Directed Completion Date: 05/12/2026

Not Implemented ([REDACTED]) - 06/23/2026

191 - Resident Right to Refuse

32. Requirements

2600.

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

Description of Violation

Resident [REDACTED] admitted to the home on [REDACTED] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident [REDACTED] admitted to the home on [REDACTED] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident [REDACTED] admitted to the home on [REDACTED] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

191 Resident Right to Refuse (continued)

Plan of Correction

Accept () - 04/14/2026

- 1) PC Director/ designee will audit resident files to ensure all they are educated on the right to refuse medications, by 4/14/2026
- 2) PC Director educated residents 4, 7,& 8 and any other residents identified in the audit on the right to refuse medication by 4/14/2026
- 3) PCHA / designee will educate medtechs by 4/14/2026 on the importance of educating residents upon admission of the right to refuse medication if they believe there is a medication error.
- 4) PCHA / designee will audits for 3 months starting 4/20/2026 to ensure that new residents are being educated on the right to refuse medication if they believe there is a medication error.

Licensee's Proposed Overall Completion Date: 04/24/2026

Implemented () - 06/23/2026

225a - Assessment 15 Days

33. 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

Resident's initial assessment, dated does not include managing health care, securing health care, doing laundry, shopping, using the telephone and making and keeping appointments.

Resident's initial assessment, dated does not include securing healthcare provider, securing and using transportation and or making and keeping appointments.

Resident's initial assessment, dated does not include making and keeping appointments.

Resident's initial assessment, dated, does not include doing laundry and mobility,

Plan of Correction

Directed () - 04/14/2026

- 1) PC Director/ designee will audit resident files to ensure all they are filling out the initial assessment form completely and not missing resident abilities by 4/14/2026
- 2) PCHA/designee will educate medtechs that the assessment must be filled out completely by 4/14/2026
- 3) PCHA/designee will audit starting 4/20/2026 for 3 months to ensure that new residents have initial assessment filled out correctly

[Directed]

- In addition to the steps above, the Administrator or designee will update Resident Resident Resident and Resident's initial assessments by 5/12/26.

Directed Completion Date: 05/12/2026

Not Implemented () - 06/23/2026

251b - Record Entries Legible

34. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on Resident [redacted]'s preadmission screening, dated [redacted] on the box for self-administration of medication.

Plan of Correction

Accept ([redacted] - 04/14/2026)

- 1) PC director/ designee will audit resident files to ensure no other resident paperwork has Correction fluid on them by 4/14/2026
- 2) PCHA/ designee will educate Medtech staff not to use correction fluid by 4/14/2026
- 3) PCHA/ designee will audit for 3 months starting 4/20/2026 new admission to ensure that staff are not using correction fluid on paperwork

Licensee's Proposed Overall Completion Date: 04/24/2026

Not Implemented ([redacted] - 06/23/2026)

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

Facility Information

Name: EMERALD PERSONAL CARE License #: 33886 License Expiration: 08/08/2026
Address: 320 MARKET STREET, ELIZABETHTOWN, PA 17022
County: LANCASTER Region: CENTRAL

Administrator

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

Legal Entity

Name: ER 320 OPERATIONS LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C 1 Date: 05/20/1996 Issued By: Department of Health

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 21 Waking Staff: 16

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Interim Exit Conference Date: 05/20/2026

Inspection Dates and Department Representative

05/19/2026 On Site: [REDACTED]
05/20/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 26 Residents Served: 21

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 5 Are 60 Years of Age or Older: 21
Diagnosed with Mental Illness: 16 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

05/19/2026 - Partial

Lead Inspector: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 06/22/2026

06/23/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/23/2026

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document Submission*

06/23/2026 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/23/2026

Reviewer: [REDACTED]

Follow Up Type: *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], Resident [redacted]'s order for [redacted] prescribed [redacted] changed from take 1 tablet by mouth once daily to take 1 tablet by mouth twice daily. Staff Member A argued with Resident [redacted] about the change in order and refused to administer the medication on [redacted] at 8:00 PM and on [redacted] at 8:00 PM.

On [redacted], Staff Member A again refused to administer the [redacted]. Staff Member A yelled at Resident [redacted] saying it would not be life-threatening if Resident [redacted] did not receive the increased dose. After Resident [redacted] showed Staff Member A the physician's order for the medication, Staff Member A walked up to where Resident [redacted] was sitting, leaned in close to the resident's face and stated "guess you got what you [redacted] wanted" while repeatedly banging on the table. Following this incident, Staff Member A refused to work the rest of [redacted] shift and left the home at approximately 3:20pm.

On [redacted], Resident [redacted] wrote in a statement that [redacted] felt intimidated and was still very upset with what had happened with Staff Member A. Resident [redacted] made a request that Staff Member A no longer provide support to [redacted] due to the lack of dignity and respect. This statement was entered on an internal complaint form and provided to Staff Member D, the administrator. However, these allegations of abuse were not reported to the local Area Agency on Aging.

Plan of Correction

Accept [redacted] - 06/23/2026

Resident [redacted]'s allegation of abuse was reported on 5/20/2026 to the local Area Agency on Aging.

A 30-day look back audit completed of internal complaint forms by July 15th to ensure any additional allegations of abuse have been reported to the local Area Agency on Aging.

PCHA and PC staff were educated on the requirements of 2600 15.a. by July 15th.

Starting on the week of July 13, 2026, PCHA / designee or designee will audit internal complaint forms twice a month for 2 months to ensure allegations of abuse have been reported to the local Area Agency on Aging.

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

15b - Supervisor Plan

2. Requirements

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

15b - Supervisor Plan (continued)

Description of Violation

On [REDACTED], Resident [REDACTED]'s order for [REDACTED] prescribed [REDACTED] changed from take 1 tablet by mouth once daily to take 1 tablet by mouth twice daily. Staff Member A argued with Resident [REDACTED] about the change in order and refused to administer the medication on 5/12/26 at 8:00 PM and on 5/13/26 at 8:00 PM.

On [REDACTED], Staff Member A again refused to administer the [REDACTED]. Staff Member A yelled at Resident [REDACTED] saying it would not be life-threatening if Resident [REDACTED] did not receive the increased dose. After Resident [REDACTED] showed Staff Member A the physician's order for the medication, Staff Member A walked up to where Resident [REDACTED] was sitting, leaned in close to the resident's face and stated "guess you got what you [REDACTED] wanted" while repeatedly banging on the table. Following this incident, Staff Member A refused to work the rest of [REDACTED] shift and left the home at approximately 3:20pm.

On [REDACTED] Resident [REDACTED] wrote in a statement that [REDACTED] felt intimidated and was still very upset with what had happened with Staff Member A. Resident [REDACTED] made a request that Staff Member A no longer provide support to [REDACTED] due to the lack of dignity and respect. This statement was entered on an internal complaint form and provided to Staff Member D, the administrator. Staff Member D started an internal investigation on 5/18/26, however, Staff Member A was permitted to work the 2:00 PM to 10:00 PM shift with no supervision plan in place.

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

Staff Member A was suspended on 5/20/2026

A 30-day look back audit completed by July 15th of internal complaint forms to ensure any additional allegations of abuse have been reported to the local Area Agency on Aging.

PCHA and PC staff were educated on the requirements of 2600 15.b. by July 15th.

Starting on the week of July 13, 2026, PCHA / designee will audit internal complaint forms and/or allegations of abuse twice a month for 2 months to that the staff person involved in the alleged incident was suspended or that there was a plan of supervision implemented per requirement.

[Directed]

- In addition to the steps above, beginning immediately, anytime allegations of abuse are made against a staff member, that staff member will be either immediately suspended pending an investigation or will immediately be put on a supervision plan.

Directed Completion Date: 07/23/2026

16c - Written Incident Report

3. Requirements

2600.

16c Written Incident Report *(continued)*

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

Description of Violation

On [REDACTED], Resident [REDACTED]'s order for [REDACTED] prescribed Magnesium supplement changed from take 1 tablet by mouth once daily to take 1 tablet by mouth twice daily. Staff Member A argued with Resident [REDACTED] about the change in order and refused to administer the medication on 5/12/26 at 8:00 PM and on 5/13/26 at 8:00 PM.

On [REDACTED], Staff Member A again refused to administer the Magnesium supplement. Staff Member A yelled at Resident [REDACTED] saying it would not be life threatening if Resident [REDACTED] did not receive the increased dose. After Resident [REDACTED] showed Staff Member A the physician's order for the medication, Staff Member A walked up to where Resident [REDACTED] was sitting, leaned in close to the resident's face and stated "guess you got what you [REDACTED] wanted" while repeatedly banging on the table. Following this incident, Staff Member A refused to work the rest of [REDACTED] shift and left the home at approximately 3:20pm.

On [REDACTED], Resident [REDACTED] wrote in a statement that [REDACTED] felt intimidated and was still very upset with what had happened with Staff Member A. Resident [REDACTED] made a request that Staff Member A no longer provide support to [REDACTED] due to the lack of dignity and respect. This statement was entered on an internal complaint form and provided to Staff Member D, the administrator. However, these incidents and the medication errors were not reported to the Department.

Plan of Correction

Accept [REDACTED] - 06/23/2026)

Resident [REDACTED]'s incident was reported on 5/20/2026 to the department's personal care home regional office.

A 30 day look back audit will be completed by July 15th of incidents to ensure it was reported 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.

PCHA and PC staff will be educated on the requirements of 2600 16.c. by July 15th.

Starting on the week of July 13, 2026, PCHA / designee or designee will audit internal complaint forms and MARs twice a month for 2 months to ensure incidents have been reported 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.

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

17 - Record Confidentiality

4. 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.

17 - Record Confidentiality (continued)

Description of Violation

The pillow packs for the medications that have been administered to residents are disposed of in the "HIPPA" trash container affixed to the side of the first-floor medication cart. This trash container has a rectangular opening cut out at the top with no cover. On [REDACTED] at 11:57 AM, this trash container was unlocked, unattended, and accessible with empty pillow packs visible in the trash container. These pillow medication packs contain resident medication information including resident's name, the name of the medication(s) that had been in the pillow medication packs, the medication dosages and the RX numbers. The empty pillow medication packs located in this trash container included medication information for Residents [REDACTED] [REDACTED] [REDACTED] and [REDACTED]

Repeated Violation - [REDACTED], et al.

Plan of Correction

Accept [REDACTED] - 06/23/2026

Facility staff made aware of HIPPA information accessible and unlocked

PCHA/ designee will educate medtech staff by 7/15/2026 on disposing HIPPA information in a secured location

Facility will remove HIPPA trash bin on side of med cart and have secured place for pill packs by 7/15

PCHA / designee will audit med carts starting the week of 7/13 twice a month for 2 months to ensure staff are securing pill packs

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

42b - Abuse

5. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [REDACTED] Resident [REDACTED]'s order for [REDACTED] prescribed Magnesium supplement changed from take 1 tablet by mouth once daily to take 1 tablet by mouth twice daily. Staff Member A argued with Resident [REDACTED] about the change in order and refused to administer the medication on [REDACTED] at 8:00 PM and on [REDACTED] at 8:00 PM.

On [REDACTED], Staff Member A again refused to administer the Magnesium supplement. Staff Member A yelled at Resident [REDACTED] saying it would not be life-threatening if Resident [REDACTED] did not receive the increased dose. After Resident [REDACTED] showed Staff Member A the physician's order for the medication, Staff Member A walked up to where Resident [REDACTED] was sitting, leaned in close to the resident's face and stated "guess you got what you [REDACTED] wanted" while repeatedly banging on the table. Following this incident, Staff Member A refused to work the rest of [REDACTED] shift and left the home at approximately 3:20pm.

On [REDACTED], Resident [REDACTED] wrote in a statement that [REDACTED] felt intimidated and was still very upset with what had happened with Staff Member A. Resident [REDACTED] made a request that Staff Member A no longer provide support to [REDACTED] due to the lack of dignity and respect. This statement was entered on an internal complaint form and provided to

42b - Abuse (continued)

Staff Member D, the administrator. Staff Member D started an internal investigation on [REDACTED] however, Staff Member A was permitted to work the 2:00 PM to 10:00 PM shift with no supervision plan in place.

During an interview on [REDACTED], Resident [REDACTED] was distraught and crying while recounting these incidents, and described feeling talked down to and belittled. Resident [REDACTED] stated that [REDACTED] did not want to go to the dining room for meals if Staff Member A was working. On [REDACTED] Staff Member A was suspended from duty and resigned from employment in response.

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

Facility staff were made aware of resident abuse concerns

Administrator to be educated by 7/15/2026 on types of resident abuse

PCHA / designee will monitor and review complaints grievance from April and May and June by 6/30/2026 looking for any abuse concerns not handled, variances will be addressed

PCHA / designee or designee will audit grievances starting the week of 7/13/2026 twice a month for 2 months to ensure they are being dealt with appropriately

[Directed]

- In addition to the steps above, the Administrator or designee will educate all staff on regulation 2600.42(b), including the different types of abuse. This will be done by 7/23/26. Documentation of this education will be kept and available for review by the Department.
- Beginning no later than 7/23/26, the Administrator or designee will interview a sample of 10% of residents monthly. Interviews will consist of inquiring about the care the residents receive from staff and if the residents feel safe and respected by staff. Documentation of these interviews will be kept and available for review by the Department.

Directed Completion Date: 07/23/2026

60a - Staff/Support Plan**6. Requirements**

2600.

60a Staff/Support Plan (continued)

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident’s assessment and support plan.

Description of Violation

On [redacted] from 6:00 AM to 10:00 PM, there were no staff scheduled certified in medication administration.

On [redacted] from 6:00 AM to 6:00 PM, there were no staff scheduled certified in medication administration.

On [redacted], from 2:00 PM to 10:00 PM, there were no staff scheduled certified in medication administration.

On [redacted], from 2:00 PM to 10:00 PM, there were no staff scheduled certified in medication administration.

On [redacted], from 2:00 PM to 10:00 PM, there were no staff scheduled certified in medication administration.

There were scheduled routine medications at the home during these times including the following:

- Resident [redacted]
- Resident [redacted]
- Resident [redacted]

There were also residents prescribed pro re nata (PRN) medications including the following:

- Resident [redacted]
- Resident [redacted]
- Resident [redacted]

Repeated Violation [redacted] et al.

Plan of Correction

Directed [redacted] - 06/23/2026)

Facility staff were made aware of staff not being scheduled that are certified in medication administration

PCHA/ Designee will educate HR by 7/15/2026 on the importance of being medication administration certified.

PCHA/ Designee will arrange for a medtech certification class to be completed by 7/20/2026

PCHA/ Designee will audit schedule starting the week of 7/20/2026 twice a month for 2 months to ensure staff are certified

[Directed]

- In addition to the steps above, the Administrator or designee will educate HR on regulation 2600.60(a), including the requirement of having a med tech on site and available during all shifts if there are PRNs prescribed in the home as well as having a med tec on site and available during the times where prescribed medications are to be administered. This will be done by 7/23/26. Documentation of this education will be kept and available for review by the Department.

Directed Completion Date: 07/23/2026

65i - Training Record

7. Requirements

2600.

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

Description of Violation

Staff Member G has a staff training sheet that does not include the date of the trainings or source of the trainings.

Plan of Correction

Directed () - 06/23/2026

Facility made aware of training record not kept

PCHA/ designee will educate HR on the requirements to keep training records by 7/15/2026

PCHA/ Designee will audit employee files by 7/15/2026 to ensure they have training records that include Date and source of training.

PCHA/ Designee will audit new employees to ensure that have training records and sources of training and date of training twice a month for 2 months starting the week of 7/13/2026

[Directed]

- In addition to the steps above, the Administrator or designee will update Staff Member G's records to include all missing information. This will be done by 7/23/26.
- The Administrator or designee will educate HR on regulation 2600.65(i). This will be done by 7/23/26. Documentation of this education will be kept and available for review by the Department.
- Beginning no later than 7/23/26, the Administrator or designee will complete quarterly audits of all current staff training records to ensure compliance. These audits will be kept and available for review by the Department.

Directed Completion Date: 07/23/2026

85a - Sanitary Conditions

8. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On () at 10:34 AM, the upstairs common shower room of the home had mold in the corner ceiling and wall which extended approximately 3 feet on one side and approximately 6 inches on the other. Above the shower curtain rod by the door of the shower room, there was another approximate 6 inches of mold at the seam of the wall and ceiling. The ceiling exhaust fan in this shower room has a layer of dust on the vents around the light fixture.

On () at approximately 1:00 PM, the windowsill of resident room () had bug carcasses, debris, dust and spider webs. There was also a black substance on and around the seal of the window.

85a - Sanitary Conditions (continued)**Plan of Correction****Directed () - 06/23/2026)**

Facility made aware of sanitary conditions, mold, dust in bathroom and bug carcasses in spider webs in resident room

PCHA/ designee will educate medtech and maintenance staff by 7/15/2026 on the importance of having sanitary conditions

Maintenance/ designee will remove the mold, dust and spider webs for noted areas and audit resident areas for mold and, dust and spider webs by 7/15/2026

PCHA/ designee will audit 5 resident rooms twice a month for 2 months to ensure areas are sanitary starting the week of 7/13

[Directed]

- In addition to the steps above, the Administrator or designee will address the mold in the upstairs common shower room. This will be done by 7/23/26. Documentation of the fix will be kept and available for the Department.*
- The Administrator or designee will immediately clean the ceiling exhaust fan and the vents around the light fixture in the upstairs common shower room.*
- The Administrator or designee will immediately clean resident room #21. The Administrator or designee will educate all staff, including maintenance staff regarding regulation 2600.85(a). This will be done by 7/23/26. Documentation of this education will be kept and available for review by the Department.*
- The Administrator or designee will complete an initial audit of sanitary conditions in the home. This will be done by 7/23/26. This initial audit will be kept and available for review by the Department.*
- Beginning no later than 7/23/26, the Administrator or designee will complete monthly audits of the sanitary conditions of the home. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: 07/23/2026

88a - Surfaces**10. Requirements**

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The rubber carpet binding strip in the lobby, located across from the concierge desk outside of the resident lounge, was loose and posed a tripping hazard.

On [REDACTED] at 10:20 AM, at the entrance to the dining room, there were areas where the linoleum tiles have lifted up and broken off.

On [REDACTED] at 10:29 AM, there was a pipe extending from the ceiling in the corner above the back entrance of the home. The pipe is a 90-degree coupling from the ceiling and turning to the back wall of the home. The hole from where the pipe comes from in the ceiling is approximately 7 inches by 4 inches. The corner of this area below the hole had peeling wall covering. This area was heavily stained with brown/reddish substance. The side wall had an electrical wire cover which is stained with approximately 8 inches of brown and black substance. There are multiple areas of brown and black spots on the seams between the ceiling and the walls in this corner.

On [REDACTED] 10:33 AM, there was peeling paint and water staining of a soffit, located across from the lounge area on the second floor.

On [REDACTED] at 10:34 AM, the ceiling exhaust fan in the upstairs common shower room had a layer of dust on the vent and a layer of dust around the light fixture.

On [REDACTED] at 10:37 AM, there was a stain, measuring approximately 18 inches by 10 inches, located on the carpet outside of resident room #59.

88a - Surfaces (continued)**Plan of Correction****Directed () - 06/23/2026)**

Facility made aware of facility surfaces in need of repair

PCHA/ Designee will educate Maintenance by 7/15/2026 on the requirement to have the facility in good repair

Maintenance/ Designee will fix the rubber strip, entrance of dining room floor tile, back entrance area by pipe, soffit by lounge, ceiling exhaust fan dust, carpet stain by #59, and look at other resident areas and address them as needed by 7/15/2026

PCHA/ designee will audit 5 resident/ area rooms twice a month for 2 months to ensure they are in good repair Starting the week of 7/13

[Directed]

- In addition to the steps above, the Administrator or designee will educate maintenance staff on regulation 2600.88(a). This will be done by 7/23/26. Documentation of this education will be kept and available for review by the Department.*
- The Administrator or designee will complete an initial audit of all surfaces in the home. This will be done by 7/23/26. This initial audit will be kept and available for review by the Department.*
- Beginning no later than 7/23/26, the Administrator or designee will complete monthly audits of the surfaces in the home. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: 07/23/2026

101o - Walls, Floors, Ceilings**11. Requirements**

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The ceiling near the right corner of resident room () had a large, dark-colored stain, which had an approximate 1-foot circumference.

The carpet in resident room () has multiple heavy carpet stains located at the entrance to and the within the room. The wall of the room at the window is painted differing shades of green. The ceiling of this room has two large dark-colored water stains above the recliner.

The ceiling in resident room () has stained ceiling tiles above the window.

The carpet outside of the bathroom in resident room () has several dark stains.

101o Walls, Floors, Ceilings (continued)

Some of the ceiling tiles in resident room [REDACTED] have large, dark brown stains.

Plan of Correction

Directed ([REDACTED] - 06/23/2026)

Facility made aware of Walls, floors & ceilings of needed repair

PCHA/ Designee will educate Maintenance by 7/15/2026 on the requirement to have Walls, floors & ceilings in good repair

Maintenance/ Designee will replace stained tiles and clean the carpet and paint affected areas and look at other resident areas and address them as needed by 7/15/2026

Maintenance/ Designee will audit 5 resident/ area rooms twice a month for 2 months to ensure they are in good repair Starting the week of 7/13

[Directed]

- In addition to the steps above, the Administrator or designee will educate maintenance staff on regulation 2600.101(o). This will be done by 7/23/26. Documentation of this education will be kept and available for review by the Department.
- The Administrator or designee will complete an initial audit of all walls, floors and ceilings in the home. This will be done by 7/23/26. This initial audit will be kept and available for review by the Department.
- Beginning no later than 7/23/26, the Administrator or designee will complete monthly audits of the walls, floors and ceilings in the home. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 07/23/2026

125b - Combustible Restrictions

12. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On [REDACTED] at 10:43 AM, there was an unlocked, unattended, and accessible can of Glitter Clear Sealer located on a cart in the upstairs hallway outside of resident room #54. The can had a warning stating, "DANGER! Extremely Flammable Liquid."

Plan of Correction

Directed ([REDACTED] - 06/23/2026)

Facility made aware of an unlocked and unattended flammable container.

PCHA/ Designee will educate Medtechs and Personal Care residents by 7/15 that these items are not allowed to be in resident areas unsupervised

PCHA immediately removed item on 5/19. PCHA/ Designee will audit all resident rooms to look for flammable items by 7/15/2026.

125b - Combustible Restrictions (continued)

PCHA/ Designee will audit 5 resident/ area rooms twice a month for 2 months to ensure they are there are no flammable items starting the week of 7/13

[Directed]

- In addition to the steps above, the Administrator or designee will educate all staff on regulation 2600.125(b). This will be done by 7/23/26. Documentation of this education will be kept and available for review by the Department.
- The Administrator or designee will complete an initial audit to look for any other flammable material available in the home. This will be done by 7/23/26. This initial audit will be kept and available for review by the Department.
- Beginning no later than 7/23/26, the Administrator or designee will complete monthly audits for flammable material in the home. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 07/23/2026

141b1 - Annual Medical Evaluation

13. Requirements

2600.

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

Description of Violation

Resident [redacted]s most recent medical evaluation, dated [redacted], does not include the resident's ability to self-administer medications.

Resident [redacted]s most recent medical evaluation, dated [redacted] does not indicate if the resident's needs can be met in a personal care home.

Resident [redacted]s most recent medical evaluation, dated [redacted], does not indicate if the resident's needs can be met in a personal care home.

Plan of Correction

Directed ([redacted] - 06/23/2026)

141b1 - Annual Medical Evaluation

Facility made aware of Resident [redacted] & [redacted] annual medical evaluation not filled out correctly

PCHA/ Designee will educate Medtech staff by 7/15 on the requirements to have an annual medical evaluation and filled out correctly

141b1 - Annual Medical Evaluation (continued)

PCHA /Designee will correct resident [redacted] & [redacted] annual medical evaluation and review all other resident annual evaluations and ensure they are correct by 7/15/2026

PCHA/ designee will audit 5 resident annual evaluations twice a month for 2 months to ensure they are accurate starting [redacted] week of 7/13/2026

[Directed]

- The Administrator or designee will complete an initial audit of all current annual medical evaluations. This will be done by 7/23/26. This initial audit will be kept and available for review by the Department.
- Beginning no later than 7/23/26, the Administrator or designee will complete quarterly audits of all current annual medical evaluations. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 07/23/2026

144c1 - Smoking Area Guidelines

14. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home does not have a designated smoking area on premises. However, on [redacted] at 9:00 AM, there were multiple cigarette butts located at the entrance to the home, under the front bench on the covered porch and under the chairs and table adjacent to the front entrance of the home. The wall at the entrance to the right of the trash can had marks indicating that cigarettes had been extinguished on the wall. The trash can contained used cigarette butts.

On [redacted] at 10:24 AM, there are several cigarette butts located in the break area, next to the dumpsters.

On [redacted] at 11:55 AM, a medical records staff person for the nursing home was smoking a cigarette in the break area, next to the dumpsters.

Plan of Correction

Accept [redacted] - 06/23/2026)

Facility staff made aware of smoking guidelines.

PCHA/ designee will educate staff by 7/15 on the no smoking on facility premises and to dispose of the cigarette butts

PCHA/ designee will ensure signs are placed by outside dumpster, bench and by facility entrance and grounds are clear of cigarette butts by 7/15/2026

PCHA/ Designee will audit areas outside facility for cigarettes butts and for signage every week for 8 weeks starting

144c1 Smoking Area Guidelines (continued)

the week of 7/13/2026

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

181c - Self-administration Assessment

15. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident [REDACTED] self administers medications to include [REDACTED] and [REDACTED]; however, the resident has only been assessed by a physician to self administer [REDACTED].

Plan of Correction

Directed ([REDACTED] - 06/23/2026)

Facility made aware of resident self administration assessment did not include all of the medications the resident was self administering

PCHA/ Designee will educate the Medtech staff of the requirements to list all the self administered medications on the support plan by 7/15/2026

PCHA/ designee will audit correct resident [REDACTED] and review all residents who self administer medication to ensure all are listed by 7/15/2026

PCHA/ designee will audit resident who self administer medication twice a month for 2 months to ensure all medications are listed starting the week of 7/13/2026

[Directed]

- In addition to the steps above, the Administrator or designee will educate med techs and residents on regulation 2600.181(c), including a resident cannot self administer medications without being assessed to do so by the resident's physician. This will be done by 7/23/26. Documentation of this education will be kept and available for review by the Department.
- Regarding Resident [REDACTED] by 7/23/26, the Administrator or designee will either remove the medications identified from Resident [REDACTED]'s room and secure them or will follow up with Resident [REDACTED]'s physician to see if the resident can self administer these medications. If the physician confirms the resident can self administer these medications, documentation the resident can self administer these medications will be obtained from the physician.

Directed Completion Date: 07/23/2026

183b Meds and Syringes Locked

16. 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 [redacted] at approximately 9:40 AM, a bottle of [redacted] was unlocked, unattended and accessible in Resident [redacted]'s room.

Plan of Correction

Accept [redacted] - 06/23/2026

Facility made aware of resident did not have an physician order for Sinex and medication was not secured

PCHA/ Designee will educate Medtech staff and residents that all medications must have a physician order and self administered medication must be secured by 7/15/2026

PCHA immediately removed the Sinex medication from residents room on 5/19/2026. PHCA/ designee will audit all resident rooms to ensure that all medications are secured by 7/15/2026

PCHA/ Designee will audit 5 resident rooms twice a month for 2 months to ensure all medications are secured starting the week of 7/13/2026

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

185a - Implement Storage Procedures

17. 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 [redacted] is prescribed testing blood sugar twice a day, at 6:30 AM and 4:30 PM. The following discrepancies were found between the blood sugar readings in Resident [redacted]'s glucometer and the blood sugar readings documented in Resident [redacted]'s May 2026 medication administration record (MAR):

- On [redacted] at 4:30 PM, the reading in the resident's glucometer was [redacted]. However, the blood sugar reading documented on the resident's MAR was [redacted].
- On [redacted] at 6:30 AM, the reading in the resident's glucometer was [redacted]. However, the blood sugar reading documented on the resident's MAR was [redacted].
- On [redacted] at 4:30 PM, the reading in the resident's glucometer was [redacted]. However, there was no blood sugar reading documented on the resident's MAR.

Resident [redacted] is prescribed testing blood sugar at bedtime, 8:00 PM. The following discrepancies were found between the blood glucose readings in Resident [redacted]'s glucometer and the blood glucose readings documented in Resident [redacted]'s May 2026 MAR:

- On [redacted] at 8:00 PM, the reading in the resident's glucometer was [redacted]. However, the blood sugar reading documented on the resident's MAR was [redacted].
- On [redacted] at 8:00 PM, the reading in the resident's glucometer was [redacted]. However, the blood sugar reading

185a - Implement Storage Procedures (continued)

documented on the resident's MAR was [REDACTED].

Resident [REDACTED] is prescribed [REDACTED] as needed for constipation. However, on [REDACTED] this medication was not available in the home.

Repeated Violation - [REDACTED] et al.

Plan of Correction

Accept ([REDACTED] - 06/23/2026)

Facility made aware of issues regarding implement storage procedures

PCHA/ Designee will educate Medtech staff by 7/15 on the requirements to document blood sugars correctly, and all medications must be available in the Med cart.

PCHA immediately obtained milk of mag for resident [REDACTED] PCHA/ Designee will review the last 30 days of Blood Sugar MAR and correct any variances and ensure all resident have their medications in the cart by 7/15.

PCHA/ Designee will Audit 5 residents twice a month to ensure they have all their medication and their blood sugar MAR is correct starting the week of 7/13/2026

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

187b - Date/Time of Medication Admin.**19. 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 [REDACTED] is prescribed [REDACTED] with orders to take 1 tablet by mouth once a day, at 6:30 AM. Resident [REDACTED]'s MAY 2026 medication administration record (MAR) does not include the initials of the staff person who administered [REDACTED] to the resident on [REDACTED] at 6:30 AM.

Resident [REDACTED] is prescribed [REDACTED] with orders to take 2 capsules by mouth once a day, at 6:30 AM. Resident [REDACTED]'s MAY 2026 MAR does not include the initials of the staff person who administered [REDACTED] to the resident on [REDACTED] at 6:30 AM, [REDACTED] at 6:30 AM and [REDACTED] at 6:30 AM.

Plan of Correction

Accept ([REDACTED] - 06/23/2026)

Facility made aware of medication record not being recorded

PCHA/ Designee will educate Medtech staff that all medication administrations must be recorded on the MAR by 7/15/2026

PCHA/ Designee will audit MARs for the last 30 days for any missed documentation and notify the provider of any missed documentation by 7/15/2026

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

PCHA/ Designee will audit 5 resident MARs twice a month for 2 months to ensure medication administration are being recorded starting the week of 7/13/2026

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

187c - Refusal of Medication

20. Requirements

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On [redacted] at 6:30 AM, Resident [redacted] refused to take a scheduled dose of [redacted]. The home did not notify the prescribing physician of the refusal.

Plan of Correction

Accept [redacted] - 06/23/2026)

Facility made aware of not notifying the provider of a medication refusals within 24hr.

PCHA/designee will educate the Medtechs that they must notify the provider of a medication refusals within 24hr unless instructed otherwise by 7/15/2026

PCHA/ Designee will notify the provider for resident [redacted] of refused medication by 7/15/2026 and audit the MAR for the last 30 days for any refusal to ensure the provider was notified by 7/15/2026

PCHA/ Designee will audit 5 resident MARs twice a month for 2 months to ensure the provider is being notified of any refusals starting the week of 7/13/2026

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

187d - Follow Prescriber's Orders

21. Requirements

2600.

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

Description of Violation

Resident [redacted] is prescribed [redacted] tablet with orders to take 1 tablet by mouth twice daily for [redacted]. However, resident was not administered this medication on [redacted] at 8:00 PM or on 5/13/26 at 8:00 PM because Staff Member A refused to administer the medication to the resident.

Plan of Correction

Accept [redacted] - 06/23/2026)

Facility made aware that medtech did not follow prescriber's orders

PCHA/ designee will educate medtech staff that they must follow physician orders by 7/15/2026

187d Follow Prescriber's Orders (continued)

PCHA/ designee will audit the MAR for the last 30 days for any medication not prescribed by 7/15/2026 and notify the prescriber.

PCHA/ designee will audit 5 resident MAR twice a month for any medication and notify the prescriber by starting the week of 7/13/2026

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

190a - Completion Medication Course

22. 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 Member A completed the initial medication administration certification on [redacted] However, Staff Member A did not have an annual practicum completed for the year [redacted] Staff Member A administered medications to the following residents:

- Resident [redacted] on [redacted] at 7:30 AM.
- Resident [redacted] on [redacted] at 8:00 PM and on [redacted] at 8:00 PM.

Staff Member B completed the initial medication administration certification on 4/26/24. However, Staff Member B did not have an annual practicum completed for the year [redacted] and the year [redacted] Staff Member B administered medications to the following residents:

- Resident [redacted] on [redacted] at 8:00 PM and on [redacted] at 8:00 PM.
- Resident [redacted] on [redacted] at 8:00 PM and on [redacted] at 8:00 PM.

Staff Member C completed the modified medication administration training, not the required standard medication administration training. Staff Member C administered medications the following residents:

- Resident [redacted] on [redacted] at 6:30 AM and on [redacted] at 6:30 AM.
- Resident [redacted] on [redacted] at 6:30 AM and on [redacted] at 6:30 AM.

Staff Member E completed the modified medication administration training, not the required standard medication administration training. Staff Member E administered medications the following residents:

- Resident [redacted] on [redacted] at 8:00 PM and on [redacted] at 8:00 PM.
- Resident [redacted] on [redacted] at 6:30 PM and on [redacted] at 6:30 PM.

Repeated Violation [redacted], et al.

Plan of Correction

Directed [redacted] - 06/23/2026)

Facility made aware of the Medtech staff working while not current on the medication administration course

PCHA/ designee will educate medtech staff and HR on the requirements to have the proper training as required by the department by 7/15/2026

190a - Completion Medication Course (continued)

PCHA/ Designee set up a training for medtech staff by 6/2/2026. PCHA/ Designee will audit staff schedule to ensure all staff have proper trainings by 7/20/2026.

PCHA/ Designee will audit the schedule weekly for 2 months starting the week of 7/20/2026 to ensure staff have the required Medtech certifications

[Directed]

- In addition to the steps above, the Administrator or designee will educate med techs and HR on regulation 2600.190(a), including all requirements of medication administration must be met in order for med techs to administer medications. This will be done by 7/23/26. Documentation of this education will be kept and available for review by the Department.
- The Administrator or designee will complete an initial audit of all current med techs records to ensure all requirements have been met for staff to be able to administer medication. Any med techs found not be in compliance with the requirements for medication administration will be removed from medication administration until they can be re-certified. This will be done by 7/23/26. This initial audit will be kept and available for review by the Department.
- Beginning no later than 7/23/26, the Administrator or designee will complete quarterly audits all current med techs records to ensure all requirements have been met for staff to be able to administer medication. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 07/23/2026

190b - Insulin Injections**23. 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.

Description of Violation

Staff Member A completed the initial medication administration certification on [REDACTED]. However, Staff Member A did not have an annual practicum completed for the year [REDACTED]. Staff Member A administered insulin to the following residents:

- Resident [REDACTED] on [REDACTED] at 8:00 AM.
- Resident [REDACTED] on [REDACTED] at 8:00 PM.

Staff Member B completed the initial medication administration certification on [REDACTED]. However, Staff Member B did not have an annual practicum completed for the year [REDACTED] and the year [REDACTED]. Staff Member B completed blood sugar testing Resident [REDACTED] on [REDACTED] at 4:00 PM.

Staff Member C completed the modified medication administration training, not the required standard medication administration training. Staff Member C completed blood sugar testing on Resident [REDACTED] from [REDACTED] at 6:30 AM and on [REDACTED] at 6:30 AM.

Staff Member E completed the modified medication administration training, not the required standard medication administration training. Staff Member E administered insulin to Resident [REDACTED] on [REDACTED] at 6:30 AM.

190b - Insulin Injections (continued)**Plan of Correction****Directed ([REDACTED] - 06/23/2026)**

Facility made aware of the Medtech staff working while they did not have the current Diabetic training.

PCHA/ Designee will educate Medtech staff on the requirements to have current Diabetic training to administer Insulin by 7/15/2026

PCHA will Audit personal care schedule to ensure all the staff have the current Diabetic training by 7/15/2026

PCHA / Designee will audit the schedule weekly for 2 months starting the week of 7/20/2026 to ensure staff have the required diabetic training.

[Directed]

- In addition to the steps above, the Administrator or designee will educate med techs and HR on regulation 2600.190(a), including all requirements of medication administration must be met in order for med techs to administer medications, including administering insulin and testing blood sugars. This will be done by 7/23/26. Documentation of this education will be kept and available for review by the Department.
- The Administrator or designee will complete an initial audit of all current med techs records to ensure all requirements have been met for staff to be able to administer medication including administering insulin and testing blood sugars. Any med techs found not be in compliance with the requirements for medication administration will be removed from medication administration until they can be re-certified. This will be done by 7/23/26. This initial audit will be kept and available for review by the Department.
- Beginning no later than 7/23/26, the Administrator or designee will complete quarterly audits all current med techs records to ensure all requirements have been met for staff to be able to administer medication, including administering insulin and testing blood sugars. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 07/23/2026