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

August 17, 2026

[redacted], GENERAL MANAGER
MG MEDIA SUBTENANT LLC
[redacted]

RE: TRUEWOOD BY MERRILL, GLEN RIDDLE
263 GLEN RIDDLE ROAD
MEDIA, PA, 19063
LICENSE/COC#: 14582

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/27/2026, 05/28/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *TRUEWOOD BY MERRILL, GLEN RIDDLE* **License #**: *14582* **License Expiration**: *02/08/2027*

Address: *263 GLEN RIDDLE ROAD, MEDIA, PA 19063*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *MG MEDIA SUBTENANT LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/01/1996* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *128* **Waking Staff**: *96*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *05/28/2026*

Inspection Dates and Department Representative

05/27/2026 - On-Site: [redacted]

05/28/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *153* **Residents Served**: *96*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Garden House* **Capacity**: *41* **Residents Served**: *25*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *96*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *32* **Have Physical Disability**: *0*

Inspections / Reviews

05/27/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/27/2026*

07/15/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/07/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/20/2026*

Inspections / Reviews *(continued)*

07/21/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/07/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/07/2026*

08/17/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/07/2026*

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

15d - Resident Abuse-Notification

1. Requirements

2600.
15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

On 5/23/2026, the home received a report of suspected abuse involving resident 1. The home did not notify resident 1's designated person.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

The designated person for Resident 1 was notified by the Med Tech on duty via voicemail, that resident 1 was going to the hospital. Med Tech requested a call back as the Med Teck did not want to leave specific information on an unsecured line of the reported incident involving suspected abuse/neglect;
The General Manager immediately reviewed the reporting and notification process with GHD and RCD to ensure notification to the resident and designated person when suspected abuse or neglect is reported immediately.
Going forward, all reportable incidents will be reviewed by RCD/General Manager/designee to confirm that required notifications are completed and documented. For alleged abuse allegations the Resident Care Director or Garden House Director shall be the one notifying the resident's designated person.
Incidents are currently being reviewed daily by the GM to ensure required notifications are completed and documented and will continue on-going.
Regional Director of Health shall be notified by RCD/GHD of any alleged resident abuse incidents to verify compliance of appropriate notification.

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

Implemented ([redacted] - 08/17/2026)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted] for resident 2 was not signed by the resident. There was no indication the resident was given the opportunity to sign.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

The resident-home contract for Resident 2 was reviewed and corrected to include documentation of the resident's opportunity to sign and/or reason the signature could not be obtained
The Business Office Manager or designee will audit all current resident-home contracts to confirm required signatures are present.
New admissions will include a contract-signature checklist prior to completion of the admission packet.
Audit of all current resident contracts will be completed by BOD/GSD by 7-31-26
GM to review all new resident files for accuracy monthly x 3 month starting 7-7-26 through 10-7-26

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/17/2026)

42b - Abuse

3. 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 5/23/2026 at 11:35 AM resident 1 and resident 3 were involved in an altercation with each other while not being properly supervised by staff, while waiting in a crowded area to enter the dining room.

Resident 1 has a diagnosis of anxiety, depression and their current support plan indicates that they can communicate effectively and can make needs known, uses a walker for ambulation and has a high potential for falls. Resident 1's support plan also indicates that the resident can be easily irritated and argumentative with others and further indicates that resident has and has history of being disruptive, aggressive, anxious, or socially inappropriate both verbally and physically, and that staff are to intervene if arguments with others begin to escalate.

Resident 3 has a diagnosis dementia, and their current support plan indicates that resident has a history of occasional difficulty remembering and using information and requires some directions and reminders from staff due to some short-term memory deficits and does not need assistance with ambulating but has a moderate potential for falls.

Prior to allowing residents into the dining area for meals, residents are brought to the hallway outside of the dining rooms and residents will congregate there between the elevators and dining room until staff opens the doors. This area becomes heavily crowded with residents as staff bring more residents to the area prior to the doors opening. However, there is no dedicated staff in the area as they are all assisting other residents down to the area for the meal service.

During this time on 5/23/26, Residents 1 and 3 were crowded together with several other residents. While waiting, resident 3 tried to enter the dining room in front of resident 1, which prompted Resident 1 to become irritated and started an argument between them. The argument escalated when Resident 3 reportedly hit resident 1 a few of times, and pushed them, causing both residents to fall to the ground. Resident 1 fell onto their back, striking their head on the floor. Other residents in the area began shouting for help in the hall, which was overhear by Staff person A, who in the dining area. Staff person A arrived in the hallway and found both residents, separated from each other and no longer fighting. Other residents in the area reported the altercation. Resident 1 stated [redacted] had hit [redacted] head on the floor but requested to have lunch before going to the hospital. The home allowed Resident 1 to eat prior to contacting an ambulance for transport to the hospital for evaluation. Resident 1 was evaluated at the hospital and was diagnosed with [redacted]. Resident 3 was assessed by the home for injury but declined evaluation at the hospital.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

The residents involved were assessed following the incident, and support plans were reviewed and updated as needed to address supervision, behavior triggers, redirection needs, and dining transition safety
The community revised the dining-room transition process to reduce crowding and ensure staff supervision in the hallway/queue area before meal service. Staff were immediately re-educated on resident rights, abuse prevention, de-escalation, supervision expectations, and immediate response to resident altercations. Formal in-service to be completed by GM 7-17-26
Wait staff in dining room observe flow of mealtime activity and report any concerns to Executive Chef/GM immmediately.

42b - Abuse (continued)

GM to conduct random rounds of dining room meals weekly to ensure all residents are safe x 3 months beginning 7-7-26 through 10-7-26

Licensee's Proposed Overall Completion Date: *07/17/2026*

Implemented (- 08/17/2026)

57c - 2 Hours/Day

4. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 5/23/2026, there were 91 residents in the home, including 27 residents with mobility needs, requiring a total minimum of 118 hours of direct care service. On this date, only 111.5 hours of direct care staffing was provided.

Plan of Correction ***Accept (- 07/21/2026)***

• Reviewed and acknowledged the 5/23/2026 staffing calculation and the requirement to schedule, document, and maintain required direct care hours.
• Added a process for the General Manager, Resident Care Director, or designee to calculate required daily direct care hours before finalizing each schedule.
• Clarified that only hours assigned to resident direct care will count toward the direct care staffing requirement.
• Required any salaried staff direct care hours to be clearly documented and separated from administrative duties.
• Resident Care Director/General Manager/Designee will monitor the schedules weekly x 3 months. July 20 through Oct 20, 2026
• Regional Director of Health Services will randomly audit schedules monthly when on site to verify compliance. July 31st through October 31, 2026

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented (- 08/17/2026)

57d - Waking Hours

5. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 5/23/2026, a total of 118 hours of direct care was required. However, only 83.25 of the required hours, or 67 percent, were provided during waking hours.

Plan of Correction ***Accept (- 07/21/2026)***

• Reviewed and acknowledged the 5/23/2026 staffing calculation and the requirement to schedule, document, and maintain required direct care hours.
• Added a process for the General Manager, Resident Care Director, or designee to calculate required daily direct care hours before finalizing each schedule to ensure adequate staffing.

57d - Waking Hours (continued)

• Clarified that only hours assigned to resident direct care will count toward the direct care staffing requirement.
• Required any salaried staff direct care hours to be clearly documented and separated from administrative duties.
• Resident Care Director/General Manager/Designee will monitor the schedules weekly x 3 months. July 20 through Oct 20, 2026
• Regional Director of Health Services will randomly audit schedules monthly when on site to verify compliance. July 31st through October 31, 2026

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/17/2026)

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

On 5/27/2026 at 9:30 AM in the bathroom of room 155 the shower and toilet seat were discolored with black flecks of dirt. At 9:34 AM In the bathroom of room 165, there was a stained towel on the chair in the shower.

On 5/28/2026 room 112 smelled of urine and the floor of the entrance way was sticky.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

The identified rooms and bathrooms were cleaned and sanitized, and stained or soiled items were removed.
Maintenance Director verbally re-educated all housekeeping staff immediately, regarding expectations for resident-room sanitation, bathroom cleanliness, odor control, and prompt removal of soiled linens or towels
Formal in-service to be completed by Maintenance Director by 7-17-26
The Maintenance Director or designee will conduct room sanitation rounds weekly for three months and address any concerns immediately. 7-7-26 through 10-7-26
GM will conduct random room audits monthly x 3 months 7-7-26 through 10-7-26

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

Implemented ([redacted] - 08/17/2026)

101o - Walls, Floors, Ceilings

7. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On 5/28/2026 the walls in bedroom 112 were splattered with black flecks of dirt around the light switch.

The carpet in room 224 had dark stains in the area near the kitchen.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

We respectfully request the first part of the violation be reconsidered as there is no room 112 here at the community
The identified wall areas were cleaned and repaired as needed, and the stained carpet area was cleaned and

101o - Walls, Floors, Ceilings (continued)

scheduled for repair/replacement as appropriate

: Maintenance Director/designee will complete room-audits weekly to identify walls, floors, and ceilings requiring cleaning or repair. Identified concerns will be entered into the maintenance log and followed through completion. Beginning 7-7-26 through 10-7-26

GM shall review weekly audits and conduct random room inspections monthly x three months. 7-7-26 through 10-7-26

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

Implemented ([redacted] - 08/17/2026)

132c - Fire Drill Records

8. 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 11/20/2025 does not include an indication of AM or PM.

The fire drill record for the drill conducted on 8/30/2025 does not include an exit route used.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

We respectfully request the first part of the violation be reconsidered as the time of the fire drill on 11-20-25 was in military time 12:00 (see attached drill)

The fire drill records were reviewed, and the community reinforced the requirement that each fire drill record include all required elements, including date, time with AM/PM, or military time, designation, evacuation time, exit route used, number of residents in the home, number evacuated, staff participating, problems encountered, and alarm/smoke detector operation.

The GM reviewed fire drill form with the Maintenance Director on 5-28

All completed fire drill records will be reviewed by the General Manager or designee within 24 hours after fire drill to ensure all information is thoroughly completed for 3 months 7-7-26 through 10-7-26

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

Implemented ([redacted] - 08/17/2026)

132d - Evacuation

9. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 9/13/2025 at 11:44 PM, only 75 of 94 residents evacuated to a public thoroughfare or a fire safe area in 16 minutes and 43 seconds

132d - Evacuation (continued)

. The home does have a maximum safe evacuation time specified in writing within the past year by a fire safety expert of 15 minutes. During this drill the home exceeded the maximum safe evacuation time.

Plan of Correction ***Accept (- 07/14/2026)***

The community reviewed the fire drill process and evacuation expectations to ensure residents evacuate to a public thoroughfare or designated fire-safe area within the maximum safe evacuation time established by a fire safety expert.
: Staff were re-educated on evacuation roles, resident movement, accountability, and escalation when residents require assistance.
Maintenance Director will conduct additional practice drills and drill reviews will be completed to evaluate timing and identify barriers on the overnight shift. To be completed by 7-31-26
All completed fire drill records will be reviewed by the General Manager or designee within 24 hours after fire drill to ensure all information is thoroughly completed and in compliance for 3 months 7-7-26 through 10-7-26

Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented (- 08/17/2026)

132h - Designated Meeting Place

10. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 9/13/2025 at 11:44 PM, 19 of 94 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area.

During the fire drill on 5/11/2026 at 7:07 PM, residents who were not in the area of the simulated fire did not evacuate to a designated meeting place away from the building or within the fire-safe area. Resident and staff reported during interviews that residents who are not in the zone of the simulated fire wait outside their rooms to be counted before returning to their rooms.

Plan of Correction ***Accept (- 07/21/2026)***

• The community will correct this violation by revising, clarifying, and reinforcing fire drill procedures to ensure all residents participate in every fire drill and evacuate to the designated meeting place away from the building or to the designated meeting place within the applicable fire-safe area, as identified in the fire safety plan and annual fire safety expert documentation.
• Maintenance Director and General Manager will be responsible for final oversight of this Plan of Correction, including ensuring completion of staff and resident education, implementation of revised fire drill procedures, monitoring for compliance, and maintenance of supporting documentation. – Training to be completed for all staff and residents by Maintenance Director and General Manager by 7-31-26
• To monitor compliance the General Manager/designee will observe and/or review documentation for three consecutive months July 31 through October 31, 2026
Fire drill to be conducted by Maintenance Director by 7-31-26 to verify compliance.
• Regional Director of Health Service will review all fire drills when on site to verify compliance

Licensee's Proposed Overall Completion Date: *07/31/2026*

132h Designated Meeting Place *(continued)*

Implemented ([redacted] - 08/17/2026)

141a 1 10 Medical Evaluation Information

11. 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. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 4's medical evaluation dated 5/16/2026 did not include the ability to self-administer medications. Additionally the document of medical evaluation (DME) form does not indicate if the resident's needs can be met in a personal care home. This information is required as part of the updated DME forms for PCH as of 7/1/2025.

Repeated Violation- 4/2/2025 et al

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

The medical evaluation for Resident 4 was reviewed, and the missing information regarding the resident's ability to self-administer medications and whether the resident's needs can be safely met in a personal care home was identified. The physician, physician assistant, or certified registered nurse practitioner was contacted to complete the missing required information on the Department-specified medical evaluation form. The completed/corrected medical evaluation will be maintained in the resident record, and the resident's service plan will be reviewed and updated as needed based on the completed evaluation.

The Garden House Director/Resident Care Director will audit all current resident medical evaluations to verify that required fields are complete, including medication regimen, contraindicated medications, medication side effects, ability to self-administer medications, mobility assessment, health status, and confirmation that the resident's needs can be met in the personal care home. Any incomplete medical evaluation will be returned to the medical provider for completion before filing. To be completed by 7-31-26

For all new admissions, annual updates, and significant changes in condition, the GHD/RCD/ designee will review the Department-specified medical evaluation form for completion prior to accepting it into the resident record. Monthly audits will be completed by GHD/RCD/Designee for three months to verify continued compliance. 7-7-26 to 10-7-26

GM to review and confirm monthly all information completed on DME's. 7-7-26 to 10-7-26

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Licensee's Proposed Overall Completion Date: *07/31/2026*

Implemented ([redacted] - 08/17/2026)

141a 1 10 Medical Evaluation Information *(continued)*

181d -Storing Medication

12. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident 5 self administers medications and stores medications in [redacted] room. Resident 5 stated during interview [redacted] stores medication on top of the microwave in the kitchen and does not always lock [redacted] door when leaving [redacted] room.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

Resident 5 was re educated by RCD regarding secure storage of self administered medications, and medications were secured in a locked location in the resident's room. A lock box was provided to secure medications.
The Resident Care Director/designee will review all residents approved for self administration to confirm medications are stored securely and that the resident understands storage expectations.
Self administration storage checks will be completed monthly and as needed by the RCD/designee x 3 months 7 7 26 to 10 7 26
GM/Designee to conduct random monthly audits x 3 months to ensure residents that are self administrating are compliant with storing medications. 7 7 26 to 10 7 26

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

Implemented ([redacted] - 08/17/2026)

182b - Prescription Medication

13. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Resident 6's [redacted] administers medications to resident 6. Resident 6's [redacted] is not a staff person of the home and is not a physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic, a graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home , A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing

182b - Prescription Medication (continued)

school faculty who is present in the home.

On 5/26/2026 and 5/27/2026 at 8:00 AM staff person B administered medications to residents to include the following; capsaicin cream .025% to resident 7's knees. Staff person B is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

On 5/16/2026 at 7:00 AM staff person C administered medications to residents to include the following; escitalopram tab 5 mg to resident 8. Staff person C is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies, because staff person C does not meet the qualifications to administer medication.

Plan of Correction ***Accept (- 07/15/2026)***

Resident # 6 - The community reviewed Resident 6's medication administration arrangement, including the resident's rights, [redacted] preference, and the physician order indicating that [redacted] may assist with/administer medications. The community also reviewed the requirements of 55 Pa. Code § 2600.182(b), which require prescription medication that is not self-administered by the resident to be administered only by a qualified licensed professional or a staff person who has completed required medication administration training. The resident [redacted] were informed that resident rights and choice will be honored to the fullest extent possible; however, medication administration practices within the personal care home must also comply with applicable regulatory requirements. Resident 6's service plan and medication administration status were reviewed. Until the arrangement is resolved in a manner consistent with Chapter 2600 requirements, medication administration by an unqualified individual within the personal care home will not continue. The community will meet with Resident 6 [redacted] to review compliant options, which may include medication administration by qualified community staff, involvement of a qualified outside provider, or transition planning if the resident [redacted] decline compliant medication administration options.

Staff person B was assisting the Med Tech during medication administration; however, because the assistance involved application of a topical prescription medication, the community directed Staff Person B not to assist with or perform medication/treatment administration tasks unless and until all applicable Department-approved medication administration training and competency requirements are completed and documented.

Staff person C We respectfully request reconsideration of the portion of this citation. Staff Person C has been employed by the community since [redacted] and was permitted to provide care under prior regulatory provisions. When the medication administration training program was implemented in 2007, Staff Person C successfully completed the required training and has maintained current medication administration training requirements. The community has maintained documentation of Staff Person C's medication administration training and competency in the employee record for review.

The Resident Care Director/ designee will audit all residents who self-administer medications or receive assistance with medications to confirm that the resident's medication status, physician orders, assessment, service plan, and medication storage arrangements are consistent with Chapter 2600 requirements. Any [redacted], family member, or outside caregiver involvement in medication support will be reviewed before implementation to confirm that the arrangement does not result in medication administration by an unqualified individual within the personal care

182b Prescription Medication (continued)

home. The resident and designated person will be informed of compliant options and the resident's right to make choices, while also documenting any risk discussion, refusal, or transition planning if compliant options are declined. Completion date 7 7 26
Garden House Director and Resident Care Director conducted in service with all med tech's on medication administration training requirements, including that unlicensed staff may administer oral, topical, eye, nose, and ear drop prescription medications only after successful completion of the Department approved medication administration course and required competency testing within the required timeframe. completed June 15, 2026
BOD/GM will confirm new hire credentials to ensure new hire meets qualifications to complete Medication Administration Training.
Prior to scheduling Med Tech training for any newly hired staff the Regional Director of Health Service, also a Certified Train the Trainer will verify qualifications.

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

Implemented ([redacted] - 08/17/2026)

183b - Meds and Syringes Locked

14. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 5/28/2026 at 9:56 AM, acetaminophen 325 mg was unlocked, unattended, and accessible in resident 6's room. Resident 6 has not been as accessed capable to self administer medications.

At 1:17 PM Metamucil powder was observed in resident 8's bedroom. Resident 8 has not been assessed as capable to self administer medications.

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

The unsecured medications observed in resident rooms were immediately secured and/or removed to an appropriate locked storage area. Residents 6 and 8 were reviewed for self administration status, and medications will not be stored unsecured unless the resident is assessed as capable and storage requirements are met. Resident #6 who lives [redacted] in apartment was provided with a lock box.
Resident #8 Metamucil was removed from the apartment, and an order was obtained from PCP' for medication to be administered by community.
GHD/RCD re educated Med Tech's regarding medication security requirements, including OTC medications, CAM, and syringes and report immediately to GHD/RCD if medication is identified in any resident apartment that does not self administer 6 15 26
The GHD/RCD/Designee will communicate with Med Tech's daily to ensure compliance ongoing

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

Implemented ([redacted] - 08/17/2026)

183e - Storing Medications

15. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 5/29/2026 lorazepam pre-filled syringes for resident 7 were in the SDCU medication refrigerator. This medication expired on 5/27/2026.

On 5/28/2026 a blister pack of Alprazolam belonging to resident 9 was found in the SDCU medication cart. The medication is 0.25mg oblong tablets cut in half, with one half table in each blister. The packaging around slot 10 appeared to have been tampered with. The blister package backing consisted of a cardboard backing over a foil backing, both had been punctured and replaced. There was less than a half of a pill in the slot which looked inconsistent with the other pills in the package, indicating the pill had possibly been replaced with some other tablet.

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

The expired lorazepam syringes were removed from active medication storage and disposed of as per protocol. The identified alprazolam blister pack was removed from use, secured, and reviewed according to the controlled substance discrepancy process. The Pa State Police were contacted, by GM and came out to the community on June 2nd. Trooper [redacted] reviewed the narcotic in question, and stated, "it looks like a bad cut." This was inconclusive as to whether it was the correct pill in the blister pack. GM requested copy of police report to submit with this POC, Trooper [redacted] declined to comply with this request.
GHD/RCD - immediately audited all Medication carts, refrigerators, and storage areas for expired, altered, or improperly stored medications
The GHD/RCD in-serviced all Med Tech's regarding medication security requirements, including OTC medications, CAM, and syringes and report immediately to GHD/RCD if medication is identified in any resident apartment that does not self-administer 6-15-26

The GHD/RCD/Designee will communicate with Med Tech's daily to ensure compliance-ongoing

GHD/RCD will conduct audits of all narcotics to ensure blister cards intact and no expired medications on med carts. weekly x 3 months. 7-7-26 to 10-7-26
GM will conduct bi-monthly random audits of all narcotics x 3 months 7-7-26 to 10-7-26
Regional Director of Health Services will conduct random monthly audit of narcotics when on site to verify compliance. 7-7-26 to 10-7-26

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

Implemented ([redacted] - 08/17/2026)

185a - Implement Storage Procedures

16. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

185a - Implement Storage Procedures *(continued)*

Description of Violation

On 5/28/2026, the 5/2026 medication administration record (MAR) and controlled substance log for resident 2's tramadol hcl 50 mg tablet was reviewed. Resident 2 is prescribed to take 1 tablet by mouth twice a day for pain. On 5/16 at 8 PM there is no signature of the staff person that signed out the medication on the controlled substance log, but it was documented as given on the MAR. On the residents MAR this medication is documented as given twice daily on 5/18, 5/19, and at 8:00 AM on 5/20, however on the controlled substance log this medication is only documented as given 4 times between 5/17 at 8:00 PM and 5/20 at 8:00 PM. On the lines for these 4 pills staff signed out the medication but did not enter a date or time. The pill count of this medication was correct. Based on staff person signatures on the MAR compared to the controlled substance log, this medication was not administered on 5/19 at 8:00 AM by staff person D.

The home's medication policy states: "1. Each time a schedule II or III medication is removed from the locked area it must be signed out on the correct page in the controlled substances records book. 2. Documentation is to include the following: a. date and time b. signature of the team member who withdrew the medication, c. amount of medication withdrawn, d. the amount of medication remaining after withdrawn"

Resident 8 is prescribed one lorazepam 1 mg tablet daily by mouth at 7 AM, 3 PM and 10 PM. The controlled substance log indicates the home received 59 pills of this medication on 5/4/2026, and on 5/23/2026, 2 pills were missing. The home had not investigated this discrepancy.

The home's medication policy states: "5. if a discrepancy is noted in the count, the team member is questioned for possible failure to sign the medication out when delivering it to the resident. If the count is not reconciled, the resident care director is notified. 6. the RCD investigates and if the count is not resolved, the general manager is notified. The general manager informs the vice president of operations. 7. the dispensing pharmacy is to be notified of unresolved count discrepancies... 8. An allegation of theft must also be reported to the appropriate state licensing agency and local law enforcement in accordance with state regulations"

The home did not implement or follow their established medications polices.

Resident 10 is prescribed 2 500-mg acetaminophen tablets every 8 hours as needed. On 5/28/2026 this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

The GHD/RCD conducted in-service with all Med Tech's and reviewed and reinforced medication storage, access, security, distribution, controlled substance documentation, discrepancy investigation, and medication availability procedures. In-service completed 6-15-26
The controlled substance documentation concerns for Resident 2 and the missing controlled substance discrepancy for Resident 8 were reviewed and investigated according to community policy, once this was identified during the state survey including notification and reporting as applicable.
The RCD immediately conducted a narcotic count of all narcotics, and all were accurate.

185a Implement Storage Procedures (continued)

GM reviewed the protocols with GHD/RCD for escalation immediately when there is a discrepancy involving narcotic count. Corrective action issued to RCD. Off Trooper [redacted] was also informed of this incident and stated, "maybe the count was off, prior, what do you want me to do." GM requested copy of police report to submit with this POC, Trooper [redacted]. declined to comply with this request.
Resident #10 prn acetaminophen tablets were ordered stat from pharmacy and reportable incident completed as per regulations.
GHD/RCD/Designee shall conduct weekly med cart audits of all narcotics administered with date, time and signature and to ensure all prn medications are available. weekly x 3 months. 7 7 26 through 10 7 26
GM to randomly audit the narcotic books monthly for accuracy x 3 months. 7 7 26 to 10 7 26
Regional Director of Health Service to conduct random monthly audit to verify accuracy of individual narcotic sheets x 3 months. 7 7 26 to 10 7 26

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

Implemented ([redacted] - 08/17/2026)

187b - Date/Time of Medication Admin.

17. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 5/19/2026 at 8:00 AM, resident 2 was not administered tramadol hcl 50 mg. Staff person D initialed the MAR, the count on the controlled substance log and current pill count indicates that the a pill was not removed to be administered at this date and time and the

Resident 7 is prescribed capsaicin cream .025% apply to knee's twice daily. Resident 7's 5/2026 medication administration record does not include the initials of the staff person who administered this medication on 5/26/2026 and 5/27/2026 at 8:00 AM. According to staff interviews, staff person C administered this medication, however, is not a staff person trained to administer medication, and staff person D initialed the MAR instead.

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

Resident 7. Please note it was staff person B not C, who was assisting the Med Tech during medication administration; however, because the assistance involved application of a topical prescription medication, the community directed Staff Person B not to assist with or perform medication/treatment administration tasks unless and until all applicable Department approved medication administration training and competency requirements are completed and documented. Both Staff Person B and Staff Person D were re educated that prescription medications, including topical medications, may only be administered by staff who meet Pennsylvania medication administration requirements and have completed approved medication administration training. GM issued corrective action for both staff person B and D.5 28 26

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

The GHD/RCD reviewed Resident 2's medication administration record, controlled substance log, and current pill count for tramadol HCL 50 mg to confirm the discrepancy related to the 5/19/2026 8:00 AM administration. The resident's prescriber and designated person were notified as applicable, and follow-up documentation was completed in the resident record in accordance with medication error procedures.
6-15-26 GHD/RCD re-educated Med Tech's that medications must be administered as prescribed, removed from the original container at the time of administration, and documented accurately on the medication administration record and controlled substance log at the time the medication is administered. Staff were also re-educated that MAR initials must reflect actual administration and must match controlled substance accountability documentation. Med Tech's also re-educated that a non-licensed staff cannot assist with applying a prescription cream.

The GHD/RCD will audit controlled substance medications and corresponding MAR documentation for residents receiving controlled medications weekly for four weeks, then monthly for two additional months. Any variance will be reviewed immediately, corrected as appropriate, and addressed through staff coaching or corrective action as indicated. Audit findings will be reviewed with the GM. 7-7-26 through 10-7-26
The Regional Director will conduct random monthly audits of the narcotics to verify compliance when on site .x 3 months 7-7-26 to 10-7-26

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

Implemented ([redacted] - 08/17/2026)

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

Resident 2 is prescribed tramadol hcl 50 mg tablet give twice daily for pain. However, resident 2 did not receive this medication on 5/19/2026 at 8:00 AM.

Resident 2 is prescribed Destin cream 13% apply to affected area every incontinence care, according to the resident's 5/2026 MAR, resident 2 did not receive this treatment at all in between 5/1/2026-5/28/26.

Resident 8 is prescribed aspirin chew 81 mg, chew and swallow 1 tablet by mouth once daily at 10 PM, however only non-chewable coated aspirin was available in the home. According to staff person E, the home has been administering the non-chewable aspirin to the resident and documenting as the chewable aspirin on the MAR.

Repeated Violation 4/2/2025 et al.

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

The GHD/RCD reviewed Resident 2's medication administration record, controlled substance log, and current pill count for tramadol HCL 50 mg to confirm the discrepancy related to the 5/19/2026 8:00 AM administration. The resident's prescriber and designated person were notified as applicable, and follow-up documentation was completed in the resident record in accordance with medication error procedures.
6-15-26 GHD/RCD re-educated Med Tech's that medications must be administered as prescribed, removed from

187d - Follow Prescriber's Orders (continued)

the original container at the time of administration, and documented accurately on the medication administration record and controlled substance log at the time the medication is administered. Staff were also re-educated that MAR initials must reflect actual administration and must match controlled substance accountability documentation.
Resident 2 Desitin Cream order was clarified by GHD the order was to read apply to affected area after every incontinence care as needed.
Resident 8's aspirin order was reconciled to ensure the medication available matches the prescriber's order.
GHD/RCD re-educated all Med Tech's that prescriber orders must be followed exactly and that any discrepancy, unavailable medication, or pharmacy substitution concern must be escalated before administration.
GHD/RCD/Designee shall conduct weekly med cart audits x 3 months 7-7-26 to 10-7-26 and review any identified concerns with GM immediately.
Regional Director Health Service will conduct random monthly med cart audits when on site x 3 month to verify compliance. 7-7-26 to 10-7-26

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

Implemented ([redacted] - 08/17/2026)

225c - Additional Assessment

19. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 3's assessment dated [redacted] shows that resident 3 has no need for assistance with aggression and agitation. Resident 3's progress notes report that on [redacted] "Continued negative behaviors to fellow residents and staff members [Resident 1] it verbally nasty to other residents and staff members, yells and complains. [redacted] taunts and makes fun of other residents and staff members" The home has not updated the resident's assessment to include these changes in needs.

Plan of Correction ***Accept ([redacted] - 07/15/2026)***

Resident 3's assessment and support plan were reviewed and updated to reflect behavioral needs, aggression/agitation concerns, supervision needs, redirection approaches, and interventions to reduce risk to the resident and others by RCD.

The GHD/RCD will review progress notes, incident reports, and change-of-condition documentation daily to identify residents requiring additional assessment prior to the annual assessment.
GHD/RCD will conduct a weekly audit x 4 weeks to ensure all service plans are updated accordingly. 7-7-26 to 8-7-26
GM reviews and approves all incident reports and will identify any significant changes that would prompt additions to the service plan and will confirm additions have been updated in the assessments with the GHD/RCD - ongoing

225c Additional Assessment (continued)

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

Implemented (- 08/17/2026)

251b - Record Entries Legible

20. 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

On resident 2's controlled substance log for tramadol hcl 50 mg the date and time for pill 19 has been crossed out and written over with a black marker making it illegible.

Correction fluid was used on resident 11's controlled substance log for lorazepam syringe 1mg/0.5 mg.

Plan of Correction ***Accept (- 07/15/2026)***

The cited controlled substance records were reviewed, and staff were re educated that resident record entries must be permanent, legible, dated, and signed by the staff person making the entry.
Staff were instructed that correction fluid may not be used and that errors must be corrected according to documentation standards, so the original entry remains readable.
In service conducted with all Med Tech's on June 15th by Garden House Director and Resident Care Director.
The Resident Care Director/Garden House Director/ designee will audit controlled substance logs and medication records weekly for three months to verify legibility, dates, signatures, and appropriate corrections. starting 7 7 26 through 10 7 26.
The GM will conduct random bi monthly audits of the controlled substance logs legibility, dates, signatures, and appropriate corrections. 7 7 26 through 10 7 26
The Regional Director Health Services when on site will conduct an audit monthly x 3 months to verify compliance. 7 7 26 through 10 7 26

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

Implemented (- 08/17/2026)