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

July 22, 2026

[redacted], REGIONAL
SH OPCO THE QUADRANGLE LLC
[redacted]

RE: QUADRANGLE PERSONAL CARE
3300 DARBY ROAD
HAVERFORD, PA, 19041
LICENSE/COC#: 14676

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/01/2026, 06/02/2026 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: *QUADRANGLE PERSONAL CARE* **License #**: *14676* **License Expiration**: *10/16/2026*

Address: *3300 DARBY ROAD, HAVERFORD, PA 19041*

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

Administrator

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

Legal Entity

Name: *SH OPCO THE QUADRANGLE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *12/17/1997* **Issued By**: *COPA*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *165* **Waking Staff**: *124*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *06/02/2026*

Inspection Dates and Department Representative

06/01/2026 On Site: [redacted]

06/02/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *143* **Residents Served**: *112*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *25* **Residents Served**: *22*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *112*

Diagnosed with Mental Illness: *2*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *53*

Have Physical Disability: *0*

Inspections / Reviews

06/01/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *07/05/2026*

Inspections / Reviews *(continued)*

07/17/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *07/21/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/21/2026*

07/22/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/21/2026*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 6/01/2026 the home's copy of 55 Pa. Code Chapter 2600, was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

The RCG biner sits at the sign in desk in the lobby along with the violation report binder, and the emergency preparedness binder. At the time the surveyor asked about the location of the regulation binder it was being utilized and was handed immediately to the surveyor. The ED has subsequently made an additional copy of the RCG so that the regulations binder should not be removed from the lobby area again.

Licensee's Proposed Overall Completion Date: *07/06/2026*

Implemented ([redacted] - 07/22/2026)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], resident #1 had an unwitnessed fall at [redacted] and was sent out to the hospital. The home did not report this incident to the Department until [redacted]

On [redacted] resident #2 passed away on [redacted] The home did not report this incident to the Department until [redacted]

On [redacted] resident #3 and resident #4 had a physical altercation at [redacted] The home did not report this incident to the Department until [redacted]

Repeated Violation - 9/10/2025, et al.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

Incidents #1, #2, and 3 were identified through the monthly audits completed by the Executive Director (ED) or designee. All reportable incidents have been submitted to the Department. The ED reviewed each occurrence to determine the factors contributing to the delayed reporting. Going forward, the Resident Care Director (RCD) or designee, who is responsible for completing reportable incident reports, will be monitored through ongoing weekly review processes to ensure timely submission of all reportable incidents. Audit findings will continue to be reviewed during Quality Assurance (QA) meetings, and corrective actions will be implemented promptly should any deficiencies be identified.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

16c Written Incident Report *(continued)*

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

Implemented ([redacted] - 07/22/2026)

17 - Record Confidentiality

3. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 6/2/2026, at 9:15 am, during a medication pass observation, there were 4 empty blister packages on top of the med cart. Staff person A scratched the resident's name with a black marker. However, it was still visible. The agent of the Department was able to see resident #5's name on the blister pack. Staff person A, disposed of the empty blister packs in the open trash can on the side of the medication cart.

Repeat Violation 5/21/2025, et al.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

The blister packs containing resident identifiers were immediately removed from the medication cart and disposed of in the facility confidential medication waste container. Staff Member A received immediate education regarding proper disposal of medication packaging containing resident information. medication staff have been re educated regarding HIPAA requirements and resident confidentiality. Medication carts are audited weekly by the LPN/Med Techs/designee to verify compliance with confidentiality requirements. Retraining will be provided if deficient practices are identified. findings will be reviewed during The quarterly QA meeting.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur

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

Implemented ([redacted] - 07/22/2026)

25b - Contract Signatures

4. 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 #5 was not signed by the resident and there is no notation as to why the resident did not sign.

Repeated Violation 11/20/2025, et al.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

Resident #5's admission contract was reviewed and signature obtained. A new admission audit completed by the

25b - Contract Signatures (continued)

sales director/designee has been implemented requiring verification that all required signatures are obtained before the admission packet is considered complete. Missing signatures will be immediately addressed. The sales director or designee will audit new admission contracts monthly for 90 days to verify completion of required signatures, findings will be reviewed during QAPI meeting

Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented (- 07/22/2026)

82c - Locking Poisonous Materials

5. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Crest toothpaste, with a manufacture's label indicating "if more than used for brushing is accidentally swallowed, get medical help or contact a poison control center right away ", was unlocked, unattended, and accessible to resident #3 in bathroom sink. Not all the residents of the home, including the resident #3, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 07/17/2026)***

The toothpaste was immediately removed from Resident #3's bathroom and secured. Resident rooms were subsequently inspected to ensure that hazardous materials are not accessible to residents who have not been assessed as capable of safely managing such items.
An additional in-service will be conducted regarding room checks during resident care, with emphasis on ensuring that hazardous items are identified, secured, and removed as appropriate during routine care activities. The Resident Care Coordinator (RCC) will also complete retraining for care managers on the proper storage and securing of hazardous materials when not in use.
Weekly environmental safety rounds will continue for 90 days, with immediate correction of any identified findings. These rounds are completed weekly by the Maintenance Coordinator or designee, Resident Care Director (RCD) or designee, RCC or designee, Care Managers, Assisted Living Supervisor or designee, Housekeeping Supervisor or designee, and Executive Director or designee.
Findings will be reported at the quarterly Quality Assurance (QA) meetings. Any deficiencies identified during rounds will be corrected immediately.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented (- 07/22/2026)

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

On 6/2/2026, at 3:04 pm, the toilet in resident #3's bathroom had a brown substance smeared on it.

Plan of Correction ***Accept (- 07/17/2026)***

Resident #3's bathroom was cleaned and disinfected immediately after the observation. Housekeeping staff were re-educated regarding daily cleaning expectations. Housekeeping Supervisor/designee will provide retraining to all housekeepers. Care Managers will be reminded to call for housekeeping assistance when they identify cleanliness concerns. Housekeeping Supervisor/Designee will conduct routine inspections at least two times weekly. Environmental sanitation audits will be completed weekly for 90 days during the weekly environmental rounds. Findings will be reported during the quarterly QA meeting.

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

Implemented (- 07/22/2026)

85d - Trash Receptacles

7. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 6/1/2026, at 10:36 am, there was a full, uncovered, unattended trash can in the main kitchen.

Plan of Correction ***Accept (- 07/17/2026)***

The uncovered trash receptacle was covered immediately. New trash can with an automatic lid closure was ordered and has been received. Dining Coordinator/Designee to provide retraining to kitchen team members.The dining coordinator or designee will inspect the kitchen daily for compliance. Finding will be documented for 90 days. Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented (- 07/22/2026)

101j5 - Bedside Table/Shelf

8. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

101j5 - Bedside Table/Shelf *(continued)*

Description of Violation

There is no bedside table or shelf beside resident #4's bed in bedroom [redacted]

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

Resident #4 had new table and lamp immediately replaced.
Resident Rooms will be audited during weekly environmental rounds to ensure required furniture and lighting is in each resident room. Room inspections are included in weekly environmental rounds to verify compliance with resident room requirements. Maintenance Coordinator or Designee will lead environmental rounds. Findings will be reported during the next quarterly QA meetings.
: Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented ([redacted] - 07/22/2026)

101j7 - Lighting/Operable Lamp

9. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #4 does not have access to a source of light that can be turned on/off at the bedside. Interviews disclosed that the resident broke the lamp, and it was not replaced or repaired.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

Resident #4 lamp was immediately replaced.
Team members were instructed to report damaged furnishings immediately for replacements. Resident rooms are inspected to ensure required furnishings are present and maintained, during weekly environmental rounds. Weekly environmental rounds checklist includes verifying compliance with resident room requirements. Maintenance Coordinator or designed will lead environmental rounds. Findings will be reported during the next quarterly QA meetings.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented ([redacted] - 07/22/2026)

103i - Outdated Food

10. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 6/1/2026, at 10:36 am, there was unlabeled, undated ice cream on top of the ice cream containers covered with a

103i - Outdated Food (continued)

baking sheet in the main kitchen.

Repeated Violation - 1/13/2026, 9/10/2025, et al.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

The ice cream was being scooped in preparation for an 11:30 am lunch start time. According to 55Pa Code Chapter 2600 food actively being prepped for an imminent meal is exempt from the strict closed-container and dating requirements. The surveyor was in the kitchen at about 10:40 am and with a lunch start time of 11:30 food/desserts were being prepared for the meal. Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

Licensee's Proposed Overall Completion Date: *07/06/2026*

Implemented ([redacted] - 07/22/2026)

104b - Dishes/Glassware/Utensils

11. Requirements

2600.
104.b. Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

Description of Violation

On 6/01/2026, while completing the physical inspection, a food cart was observed delivering residents meals on styrofoam containers. During interviews with residents and staff members, it was verified that the meals were delivered in styrofoam containers.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

The facility discontinued the routine use of Styrofoam meal containers. A form was developed for residents to note their preferences for room service or dining room service. The form is attached. This offers residents the opportunity to select how they would like their food and drinks delivered. If a resident has a preference other than china, glass and silverware it will be noted in the ISP and signed form will be in the paper medical chart. Dining team members were educated regarding regulatory requirements governing meal service. The dining department will maintain an adequate inventory of reusable dishes and utensils to meet resident needs. The dining coordinator or designee will observe meal service weekly for 90 days to ensure reusable dishware is utilized appropriately.

Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented ([redacted] - 07/22/2026)

141b1 - Annual Medical Evaluation

12. Requirements

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

Description of Violation

Resident #6's most recent medical evaluation was completed on [redacted] However, there is no option selected indicating that the resident's needs can be met safely met at the home.

Resident #7's most recent medical evaluation was completed on [redacted]. However, there is no option selected indicating that the resident's needs can be met safely met at the home.

Repeated violation - 2/2/2026, et al.,11/20/2025, et al., 9/10/2025, et al.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

The medical evaluations for residents #6 and 7 were reviewed with their respective primary care providers. Updated DME forms were obtained indicating whether the resident's needs can be safely met in the home. The RCD/WN/designee audited resident medical evaluations to ensure required sections were completed and if they were not, they are being updated by pcp. The RCD or designee will audit randomly new and annual medical evaluations weekly for 90 days to ensure they are complete and include required documentation. Deficiencies will be corrected immediately. Findings from the audit will be reviewed will be reviewed at the quarterly QA meeting.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented ([redacted] - 07/22/2026)

141b2 Medical Evaluation Changes

13. Requirements

2600.
141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident #8's most recent medical evaluation for a change in status dated [redacted] did not include the resident's ability to self-administer medications.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

Resident #8 DME was reviewed by the PCP and updated evaluation documenting the resident's ability to self-administer medications was obtained. RCD/Wellness Nurse reviewed the other residents that self-medicate to confirm that it is reflected on the latest DME. The RCD or designee will randomly audit change of condition DME's for 90 days to verify completeness. Results of audit will be reviewed in the quarterly QA meeting.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented ([redacted] - 07/22/2026)

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 6/01/2026, at 9:35 am, there were several over-the-counter medications and creams, such as CeraVe, Prevent Silicone Cream, Dermal Wound Cleanser, Skintegrity Cleanser, in resident #9's bedroom on top of [redacted] cabinet; however, resident #9 does not self-administer medications.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

The over-the-counter medications and topical creams found in resident #9s room were immediately removed and secured in the locked medication cart. Resident #9 does not self -administer medications. During weekly environmental rounds we will also check for any unsecured medications/topicals in resident apartments. Any unsecured medications identified will be removed immediately and re-education of staff will take place as needed. Results of rounds will be reviewed in the quarterly QA meetings.

Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented ([redacted] - 07/22/2026)

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

Resident #10 is prescribed morphine sulfate 20 mg/ml soln take 0.025 ml (5mg) by mouth or under the tongue every 2 hours as needed for pain or shortness of breath. On 6/2/2026, 19 syringes were available on the medication cart with an expiration date of 1/23/2026. The medication was last administered to resident #10 on 3/17/2026 at 12:05.

Resident #10 is prescribed ABH 1/25/1 Gel apply 1ml to inner wrist or other hairless area every 2 hours as needed for anxiety or agitation or restlessness. On 6/2/2026, the medication was still available on the medication cart with an expiration date of 4/7/2026 with a remaining count of 30.

Resident #10 is prescribed ABH 1/25/1 Gel apply 1ml to inner wrist or other hairless area every 2 hours as needed for anxiety or agitation or restlessness. On 6/2/2026, the medication was still available on the medication cart with an expiration date of 4/20/2026 with a remaining count of 30.

Resident #10 is prescribed ABH 1/25/1 Gel apply 1ml to inner wrist or other hairless area every 2 hours as needed for anxiety or agitation or restlessness. On 6/2/2026, the medication was still available on the medication cart with an expiration date of 4/30/2026 with a remaining count of 4.

183e Storing Medications (continued)

On 6/2/2026, at 2:22 pm, there was one loose pill in the medication cart in the special care unit. Staff was unable to identify the medication.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

All expired medications, including the expired morphine syringes, and ABH gel, were immediately removed from active medication storage and disposed of in accordance with facility policy and applicable regulations. The unidentified loose tablet was removed from the medication cart and properly discarded after it could not be identified. Refresher training to be completed by RCD to review expiration dates of medications and syringes when completing weekly cart audits.

The pharmacy has concluded an entire house medication cart audit. The Wellness nurses/med techs/RCD will continue to complete weekly cart audits and monitor for expiration dates. Audit results will be reviewed during QA and corrective action will be implemented for any identified deficiencies.

Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented ([redacted] - 07/22/2026)

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.

Description of Violation

Resident #11's glucometer was not calibrated. On 6/2/2026, at 2:20 pm the glucometer for resident #11 read 6/2/2026 at 3:12 pm.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

Resident #11's glucometer date and time were immediately corrected and verified for accuracy. Facility glucometers were inspected to ensure proper date, time and calibration settings. Refresher training will be provided by RCD on proper calibration of the glucometer. Med techs/Wellness Nurse/RCD will audit all glucometers weekly for 90 days to ensure proper calibration and accurate date and time settings.

Audit results will be reviewed during QAPI meeting and corrective action will be implemented for any identified deficiencies. Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented ([redacted] - 07/22/2026)

191 - Resident Right to Refuse

17. 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.

191 - Resident Right to Refuse *(continued)*

Description of Violation

Resident #3, admitted 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 #4, admitted 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 #5, admitted 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 #8, admitted 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 #12, admitted on [redacted], has not been educated about the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

ED and Sales Director completed a Resident rights audit showed that residents that moved in from March 2025 through June 2026 received resident rights that had inadvertently had the right to refuse cut off. ED provided an update on resident rights at the June Resident Council meeting. ED, RCC, AVC and Admissions Coordinator will visit residents one on one and obtain signatures. ED also sent the form out to families/responsible parties via email. residents have been re-educated starting in the June 2026 resident council meeting on 6/25/26.
Updated resident rights forms have been developed, and residents and/or families will have their rights reviewed and they will be asked to sign updated resident rights document. The updated rights will be placed in the resident's business office file. Sales Director/Designee will complete monthly random resident business file audits. Audit results will be reviewed during the next two QAPI meeting and corrective action will be implemented for any identified deficiencies
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur

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

Implemented ([redacted] - 07/22/2026)

227a - Support Plan 30 Days

18. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #8 was admitted on [redacted] the resident's initial support plan was not completed until [redacted]

227a - Support Plan 30 Days (continued)

Resident #12 was admitted on [redacted] however, the resident's initial support plan was not completed until [redacted]

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

Retraining for the RCC/RCD to complete the initial support plan and review with resident/family by day 30 will be completed. New move-in ISP completion will be audited by day 30 to ensure completion within the required timeframe. Findings from the audit will be reviewed during the quarterly QA meeting.

Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented ([redacted] - 07/22/2026)

227b - Support Plan Content

19. Requirements

2600.
227.b. A home may use its own support plan form if it includes the same information as the Department's support plan form.

Description of Violation

The home does not use the Department's support plan form. The home's support plan does not include all behavioral needs such as irritability, judgment, agitation, aggression, and hallucinations. The support plan dated [redacted] for resident [redacted] states the goal for Mood and Behaviors: "My mood state will not interfere with care needs being met through the next review date." The intervention states: "Encourage and engage me to participate in my own care." Give me a clear explanation of all care activities prior to and as they occur during each contact" and "Introduce yourself and anyone who will be assisting me." "Monitor my behavior/my interaction with my peers and document, especially when I am in common areas."

However, the assessment does not document on how the need will be met or the frequency.

Repeated Violation - 11/20/2025, et al.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

Resident [redacted] support plan was revised to accurately reflect all identified behavioral needs, including interventions, frequency of care and individualized approaches to meeting those needs. The RCD/RCC/ Wellness Nurses will receive education regarding identifying and documenting the individual resident needs on the ISP. RCD/RCC or designee will audit random support plans each month for 90 days to verify completeness, accuracy and individualized interventions. Findings from the audit will be reviewed at the quarterly QA meeting. Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented ([redacted] - 07/22/2026)

227b - Support Plan Content *(continued)*

227g -Support Plan Signatures

20. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #5 participated in the development of [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

Resident #13 participated in the development of [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

Repeated Violation - 2/12/2026, 11/20/2025, et al., 5/21/2025, et al.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

Residents 5 and 13 were offered the opportunity to sign their support plans. When residents are unable to decline to sign the ISP signature page a notation on the signature page of this will be made explaining the reason. Refresher training will be provided by ED to the RCC on obtaining signatures to documenting the resident's inability to sign. RCC/Designee will review new and revised support plans monthly for 90 days to verify required signatures are present. The findings will be reviewed at the quarterly QA meeting.

Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur

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

Implemented ([redacted] - 07/22/2026)

251b - Record Entries Legible

21. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident #7's most recent medical evaluation dated [redacted]; the dates were written over.

Resident #14's most recent medical evaluation dated [redacted]; the dates were written over

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

Resident #7 and 14 DME were reviewed the dates appeared legible but corrected copies were requested to eliminate any discrepancy. RCD/Designee will conduct monthly random resident record audits for 90 days to verify legibility, accuracy, and use of current standardized forms. Any identified deficiencies will be corrected immediately, and additional staff education will be provided when necessary.

251b Record Entries Legible (continued)

Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur

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

Implemented ([redacted] - 07/22/2026)

251c - Standardized Forms

22. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident #5's medical evaluation form, dated [redacted] was not completed on the Department's current standardized form.

Repeated Violation 11/20/2025, et al.

Plan of Correction ***Accept ([redacted] - 07/17/2026)***

Resident #5's DME was updated using the correct personal care DME form taken from the Department's website. ED provided refresher training to the wellness nurse on how to identify the correct version of the DME to use. DME's will be randomly audited by RCD/designee for 90 days and at the end of the 90 days current resident DME's will have been reviewed and any violations corrected. Findings will be reviewed at the quarterly QA meetings.
Executive Director is responsible for confirming the implementation and compliance of this POC and addressing and resolving any variations that may occur.

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

Implemented ([redacted] - 07/22/2026)