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

August 25, 2026

[redacted], EXECUTIVE DIRECTOR
NORTHEAST PC OPERATIONS LLC
773 EAST HAVERFORD ROAD
BRYN MAWR, PA, 19010

RE: BRYN MAWR VILLAGE
773 EAST HAVERFORD ROAD
BRYN MAWR, PA, 19010
LICENSE/COC#: 14834

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/03/2026, 06/12/2026 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: *BRYN MAWR VILLAGE* **License #**: *14834* **License Expiration**: *10/16/2026*

Address: *773 EAST HAVERFORD ROAD, BRYN MAWR, PA 19010*

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

Administrator

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

Legal Entity

Name: *NORTHEAST PC OPERATIONS LLC*

Address: *773 EAST HAVERFORD ROAD, BRYN MAWR, PA, 19010*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *09/30/2014* **Issued By**: *Haverford Township*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *06/12/2026*

Inspection Dates and Department Representative

06/03/2026 - On-Site: [redacted]

06/12/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *25* **Residents Served**: *11*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Home* **Capacity**: *25* **Residents Served**: *11*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *11*

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

Have Mobility Need: *11* **Have Physical Disability**: *3*

Inspections / Reviews

06/03/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/10/2026*

Inspections / Reviews *(continued)*

08/25/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *07/09/2026*
Reviewer: [redacted]
Follow Up Type: *Bypass Document Submission*

08/25/2026 Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *08/25/2026*
Reviewer: [redacted]
Follow Up Type: *Not Required*

51 - Criminal Background Check

1. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Agency staff Members A, B, C and administrator [redacted] did not have record of a criminal background check completed prior to their first day of working at the home.

Repeated Violation- 4/17/25

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. Facility cannot retroactively correct. Staff Member A's background check was obtained through [redacted] staffing agency's file, confirming completion on [redacted] Staff Member B's background check was obtained through [redacted] staffing agency's file, confirming completion on [redacted]. Staff Member C's background check was obtained through [redacted] staffing agency's file, confirming completion on [redacted] Agency staff members who were cited (Staff Members A, B, and C) were removed from picking up shifts at the facility until their background check documentation was confirmed. Completion date for this was 06/15/2026. [redacted] background check documentation for this current in house staff member cited was obtained and confirmed. Completion date for this was also [redacted] All four background checks reflect no disqualifying findings. Responsible party: HR Director.

2. Root cause: A transition in the HR Director position created a gap in enforcement of the requirement that background check documentation, whether facility initiated or agency provided, be confirmed and filed prior to an employee's first shift. HR Director was educated on this regulation on 7/6/2026. Responsible Party: HR Director.

3. A new employee onboarding checklist was implemented under the new HR Director, who started in [redacted]. The checklist requires that for new staff a background is completed. As for agency supplied staff, HR obtains and files a printed copy of the agency completed background check prior to the individual's first scheduled shift. For directly hired staff, HR confirms a completed background check prior to first shift. No employee, agency or in house, may be added to the schedule until this is confirmed. Responsible party: HR Director.

4. HR Director/Designee will conduct a monthly audit of new hire files, both in house and agency, to confirm background check documentation is on file prior to first day of work. Findings will be reviewed at monthly QAPI and QI meetings. Responsible party: HR Director. Ongoing, beginning 6/1/2026.

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

65a - FS Orientation 1st Day

2. Requirements

2600.

65a - FS Orientation 1st Day *(continued)*

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

Agency staff person A, whose first day of work was [redacted] agency staff person B, whose first day of work was [redacted] and agency staff person C, whose first day of work was [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, smoke detectors and fire alarms, telephone use and notification of emergency services.

Repeated Violation- 4/17/25

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. Facility cannot retroactively correct. The agency staff members cited have not returned to work at the facility since the citation was issued and are no longer scheduled for shifts. The facility's existing orientation binder, which addresses all required fire safety and emergency preparedness topics for staff working off hours or off shifts, was reviewed to confirm content remains current and complete. Date completed 6/21/2026. Responsible party: Administrator and HR.

2. Root Cause Identification and Education: For agency staff filling shifts on short notice, first day fire safety orientation was not consistently completed and documented before the individual began working, creating a gap between the facility's orientation binder process and confirmation that each agency staff member actually completed it prior to their first shift. To address this, the Administrator will educate HR on this regulation as it relates to onboarding of new employees. The governing body will educate the Administrator on this regulation and on ensuring agency staff have signed off on this orientation prior to starting their shift. Completion date 7/6/2026. Responsible party: Administrator and HR.

3. The facility's existing orientation checklist will be used to document completion of first day fire safety orientation for every staff member prior to their first shift. For directly hired staff, HR is responsible for scheduling and confirming completion of orientation, which is conducted by each department head, with unit specific review by the Administrator for staff assigned to personal care. For agency staff filling shift needs, the Administrator, or the med nurse on duty as backup in the Administrator's absence, is responsible for confirming the agency staff member

65a FS Orientation 1st Day (continued)

reviews the orientation binder and completes the orientation checklist before beginning their first shift. No staff member, agency or in house, may begin a shift until the completed and signed checklist is on file. Responsible party: Administrator and HR Director.

4. Administrator will conduct a monthly audit of orientation checklists for all new agency and in house staff to confirm fire safety orientation was completed and documented prior to first shift. Findings will be reviewed at monthly QAPI and QI meetings. Responsible party: Administrator. Ongoing, beginning 6/1/2026.

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff Member D did not receive training in medication self administration training, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, and Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training years June 2025 through May 2026.

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. Staff Member D will complete all missing required annual training topics, including medication self administration, infection control and cleanliness and hygiene principles, and care for residents with mental illness or an intellectual disability. Responsible party: Administrator. Completion Date: 07/8/2026.

2. Root Cause: Staff Member D attended the majority of scheduled annual training sessions during the training year but missed one month's training session, resulting in incomplete coverage of all required annual topics for that training year. Administrator will be trained on ensuring she is tracking mandatory trainings and understanding the regulation. completion date 7/6/2026.

65f - Training Topics (continued)

3. The Administrator will maintain a monthly training attendance tracker that is cross referenced against the full list of required annual training topics for each staff member. Any staff member who misses a scheduled monthly training session will be flagged immediately and scheduled for make up training within the same month, rather than allowing the gap to carry through to the end of the training year. Responsible party: Administrator.

4. Administrator will conduct a monthly review of the training tracker to confirm all staff members are current on required annual training topics and that any missed sessions have been made up. Findings will be reviewed at monthly QAPI and QI meetings. Responsible party: Administrator. Ongoing,

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

65g - Annual Training Content

4. 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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff persons D and E did not receive training in 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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights during training year June 2025 through May 2026.

Repeated Violation- 4/17/25

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1.Staff Member D will complete all missing required annual training topics, including fire safety, emergency preparedness and crisis response, and resident rights. Staff Member E is no longer employed at the facility and is no longer applicable to this corrective action. Responsible: Administrator. Completion Date: 07/8/2026

2. Staff Member D missed a scheduled month of training sessions during the training year, resulting in incomplete coverage of all required annual topics for that training year. Administrator will be educated to maintain and track the monthly training attendance tracker, cross-referenced against the full list of required annual training topics for

65g - Annual Training Content (continued)

each staff member.Responsible: Administrator. Completion Date: 07/8/2026

3. The Administrator will maintain the monthly training attendance tracker, cross-referenced against the full list of required annual training topics for each staff member. Any staff member who misses a scheduled monthly training session will be flagged immediately and scheduled for make-up training within the same month, rather than allowing the gap to carry through to the end of the training year. Responsible: Administrator. Completed: 07/8/2026

4. Administrator will conduct a monthly review of the training tracker to confirm all staff members are current on required annual training topics and that any missed sessions have been made up. Findings will be reviewed at monthly QAPI/QI meetings. Responsible: Administrator. Ongoing, beginning: 07/1/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

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

On 6/3/26, there was an unlocked door in the east wing referred to as a "Conference Room", which contained numerous square basins of resident toiletries and care products. Those products included lotions, toothpastes, mouthwashes and skin barrier protectants. Some of these items had warning labels indicating to contact poison control or seek medical attention if improperly ingested.

On 6/12/26, there was a shower bin in Resident 1's bathroom which contained Colgate toothpaste,had a warning label present to contact poison control or seek medical attention if accidently ingested. The resident has not been assessed as able to safely use poisonous materials.

Repeated Violation- 4/17/25

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. The Conference Room storage area has been secured and locked, and a sign was placed on the door reminding staff to keep it locked and not left propped open. The poisonous product identified in the resident's shower bin was secured immediately upon identification during the survey. Responsible: Nursing/Administrator/Maintenance. Completed: 06/12/2026

2. The Conference Room door was left open during an evacuation event while items were being moved in and out of the space; the door is otherwise typically kept secured and locked. A sign was posted on all secured areas reminding all staff to keep doors secured. Completed: 6/12/2026 Identified by: Nursing/Administrator/Maintenance

82c - Locking Poisonous Materials (continued)

3. All staff were educated to ensure storage area doors, including the Conference Room and any area containing poisonous materials, are shut and locked immediately after use, and that doors are not to be left propped open, including during and after events such as evacuations. Responsible: Administrator/Nursing. ongoing begining of 6/12/2026

4. A weekly audit will be conducted confirming all storage areas containing poisonous materials remain secured and locked. Any area found unsecured will be corrected immediately, documented, and reported at the next QAPI/QI meeting if recurring. Responsible: Nursing/Maintenance/Administrator. Ongoing, beginning: 06/12/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

107d - Procedure Emergency Management Agency Submission

6. Requirements

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

Description of Violation

The home's written emergency procedures have not been sent to the local emergency management agency since 5/15/2025.

Repeated Violation- 4/17/25

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. The facility's written emergency procedures were reviewed, updated, and submitted to the local emergency management agency via email on 06/12/2026. Responsible: Administrator. Completed: 06/12/2026

2. The Administrator was new to the position during the period this submission was due and was not yet aware of the annual requirement to submit written emergency procedures to the local emergency management agency, resulting in the submission being missed. With last submission being done sometime in April of 2025. Administrator was educated on this regulation on 6/12/2026 and immediately sent information over. Responsible: Administrator. Completed: 06/12/2026

3. A calendar outlook reminder has been put in place with the governing body to prompt the governing body to notify the Administrator annually ahead of the due date to submit the written emergency procedures to the local emergency management agency, ensuring this requirement is not missed going forward regardless of any future turnover in the position. Responsible: Governing Body/Administrator. Completed: 06/12/2026

107d Procedure Emergency Management Agency Submission (continued)

4. Administrator will confirm annually that emergency procedures have been submitted to the local emergency management agency and will retain documentation of submission (email confirmation or receipt) on file. This will be reviewed at monthly QAPI/QI meetings during the month the submission is due. Responsible: Administrator. Ongoing, beginning: 06/12/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

131f - Fire Extinguisher Inspection

7. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguishers in the Impressions area, main kitchen, and kitchen pantry have not been inspected by a fire safety expert since 5/2025.

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. Expired fire extinguishers in the Impressions area, main kitchen, and kitchen pantry were removed and replaced with newly inspected fire extinguishers on 06/12/2026. Current inspection tags are dated May 2026 and are valid through May 2027. Responsible: Maintenance Director. Completed: 06/12/2026

2. The facility contracts with Keystone for inspection and servicing of all fire safety equipment, including extinguishers, alarms, and sprinklers, and this service is maintained on a tracking system by the Maintenance Director. Keystone was originally scheduled to switch out and inspect the fire extinguishers in May 2026; however, this service was placed on hold by the governing body due to the extinguisher count being higher than normal, which automatically delayed the scheduled swap out and inspection. It was also noted that some non expired extinguishers were not switched out at the time of replacement. Responsible: Maintenance Director. Completed: 06/12/2026

3. When a hold is placed on a scheduled Keystone service by the governing body, the Maintenance Director will immediately identify and implement an interim solution, such as temporary replacement units (BACK UPS which the facility has 8 back ups in place), to ensure fire safety equipment does not lapse out of compliance while the hold is being resolved. The existing tracking system will be updated to flag any held or delayed service so it is escalated and resolved before equipment expires. Responsible: Maintenance Director/Governing Body. Completed: 06/12/2026

4. Maintenance Director will conduct a monthly review of the fire safety equipment tracking system to confirm all extinguishers, alarms, and sprinklers are current and inspection tags have not expired or are not approaching expiration. Findings will be reviewed at monthly QAPI/QI meetings. Responsible: Maintenance Director. Ongoing, beginning: 06/12/2026

131f - Fire Extinguisher Inspection (continued)

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

132f - Alternate Exit Routes

8. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The Dining Room was the only exit route used during the fire drills held from 7/25 to 9/25 and on 12/25.

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. A fire drill was conducted in June 2026 using the Hallway exit route. Responsible: Maintenance Director. Completed: 06/30/2026.

2. The Dining Room exit route was routinely used because it was considered the easiest route to manage given that this is a secured, locked dementia care unit. A updated tracker log was made to assist with alternating exit routes. Responsible: Maintenance Director. Completed: 07/7/2026.

3. A fire drill exit route rotation log was developed for the Maintenance Director's use, alternating among all three designated exit routes (Dining Room, Main Hallway, and Sun Porch/Solarium) as well as varying the shift and time of each drill, so no single route or schedule pattern is routinely repeated. Responsible: Maintenance Director. Completed: 06/30/2026

4. Maintenance Director will conduct monthly fire drills according to the rotation log, documenting the exit route used, date, and shift for each drill. Findings will be reviewed at monthly QAPI/QI meetings. Responsible: Maintenance Director. Ongoing, beginning: 06/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

132g - Fire Drills Days/Times

9. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely held fire drills on the last week of the month, during 2025, as evidenced by the following drills: 6/25, 7/25, 8/25, 9/25, 10/25, 11/25, and 12/25/2025.

132g Fire Drills Days/Times *(continued)*

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. A fire drill was conducted in June 2026 on a varied day and shift (Evening), rather than following the previous pattern of routinely scheduling drills during the last week of the month. Responsible: Maintenance Director. Completed: 06/30/2026

2. Fire drills were routinely scheduled for the last week of the month as a matter of convenience, resulting in a consistent, predictable pattern rather than the varied days and times required by regulation. Maintence Director was educated on this regulation. Responsible: Maintenance Director. Completed: 06/30/2026

3. The fire drill exit route rotation log developed for the Maintenance Director's use also varies the scheduled day of the week and shift/time (day, evening, and night) for each monthly drill, ensuring drills are not routinely held on the same day, at the same time, or during predictable staffing or attendance patterns. Maintenance Director was educated on this updated log made. Responsible: Maintenance Director. Completed: 06/30/2026

4. Maintenance Director will conduct monthly fire drills according to the rotation log, documenting the date, day of week, and shift for each drill to confirm ongoing variation. Findings will be reviewed at monthly QAPI/QI meetings. Responsible: Maintenance Director. Ongoing, beginning: 06/30/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

141a 1-10 Medical Evaluation Information

10. 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 1's initial medical evaluation did not include an evaluation or completed date.

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. The resident was admitted to the facility on [redacted] There have been several changes in Administrator since that time. Per DHS DME correction protocol, current facility staff contacted the physician who performed the evaluation to verify the date of assessment completion. The physician confirmed the resident was seen and

141a 1 10 Medical Evaluation Information (continued)

evaluated on [redacted]. This was documented on the DME, including the date, time, and person spoken to, per DHS requirements for correcting a DME. Responsible: Administrator. Completed: 07/02/2026

2. An audit/review of the resident's admission record was not completed by the Administrator at the time of admission, or by subsequent Administrators since, to confirm the DME and other required admission documentation were complete and in compliance. Adminstrator was educated on this regulation. Responsible: Administrator completed on 7/2/2026.

3. An admission checklist has been put into place, requiring the Administrator to confirm that the medical evaluation, including the evaluation date and form completed date, and all other required admission documentation are complete before the resident's record is considered finalized. Responsible: Administrator. Completed: 07/07/2026

4. Administrator will use the admission checklist for every new admission going forward and will conduct a periodic audit of resident records to confirm required fields, including evaluation and completion dates, remain complete. Findings will be reviewed at monthly QAPI/QI meetings. Responsible: Administrator. Ongoing, beginning: 07/07/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

183e - Storing Medications

11. 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 6/12/26, Resident 2 had eight (8) Morphine syringes, [redacted], in medication cart which had expired 2/15/2026.

Repeated Violation 4/17/25

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. The expired Morphine syringes were removed from the medication cart and destroyed at the facility per facility protocol on 06/12/2026, with (2) nurses to oversee the destruction. Destruction was documented on the Resident Controlled Drug Accountability record, including amount destroyed and signatures of staff present. A full audit of all narcotics in the facility was also completed on 06/12/2026 by the governing body; no other expired narcotics were noted or found. Responsible: Administrator/Nursing/Governing Body. Completed: 06/12/2026

2. The expired medication was previously identified during an audit prior to the surveyor identifying it. However, the finding was not followed up on or acted upon by nurses resulting in the expired medication remaining in the cart

183e - Storing Medications (continued)

until the survey. A full audit of all narcotics in the facility was also completed on 06/12/2026 by the governing body; no other expired narcotics were noted or found. Responsible: Administrator/Nursing/Governing Body. Completed: 06/12/2026

3. The Administrator is responsible for ensuring the nurses are given the approval to destroy narcotics if noted to be expired by nursing staff. Per facility protocol, destruction of expired controlled substances on the personal care side requires administrator review for approval along with a witness of a second nurse when destroying a narcotic. Any findings identified to be expired will be followed up on and resolved by the Administrator immediately, rather than left unaddressed. Responsible: Administrator. Completed: 06/12/2026

4. Administrator will conduct a monthly review of all Narcotics to ensure expired medications are disposed of per facility protocol. Any findings from nurses related to medication storage and expiration will be followed up on and resolved in a timely manor. Findings will be reviewed at monthly QAPI/QI meetings. Responsible: Administrator. Ongoing, beginning: 06/12/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

184a - Resident's Meds Labeled

12. 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

The pharmacy label for resident 3's Atorvastatin Calcium Oral Tablet [redacted] did not match the description on the June 2026 Medication Administration Record which read take one tablet [redacted].

Plan of Correction ***Directed ([redacted] - 07/10/2026)***

1. A verbal order was obtained from the resident's physician on 6/18/2026 to clarify and update the order, confirming the resident is to receive [redacted] once daily. The order was updated to reflect this dosing so the pharmacy label and MAR match. Pharmacy conducted a cross-check confirming the MAR and medication now match. Responsible: Pharmacy Consultant/Physician. Completed: 06/18/2026

2. This was a pharmacy labeling error. Identified by: Pharmacy Consultant

184a - Resident's Meds Labeled (continued)

3. The pharmacist consultant is responsible for ensuring the MAR matches each resident's active order. Governing Body completed a full cross-check of MARs against current orders to confirm no other discrepancies exist. Responsible: Governing Body . Completed: 06/18/2026

4. Pharmacy will complete a monthly cross-check of all MARs against active orders to confirm labels and MARs match for every resident. Findings will be reviewed at monthly QAPI/QI meetings. Responsible: Pharmacy Consultant. Ongoing, beginning: 06/18/2026

Directed Plan of Correction ([redacted] 7/10/26):

In addition to the steps noted in the submitted Plan of Correction, the administrator will implement the following steps:

1. The administrator or nursing staff will conduct a month end audit of all resident medication to ensure the pharmacy label and MAR match, starting immediately, and continuing for the next six (6) months.

2. The administrator will conduct a training with all staff administering medications on how to identify discrepancies between the pharmacy label and the MAR, within the next 15 days. A record of the training and staff sign in will be maintained for the Departments reviews.

3. The administrator will review the pharmacy audits, at least bi-monthly, to ensure all resident medications are being correctly administered, starting immediately for the next six (6) months. A copy of the review will be maintained for the Departments review.

Proposed Overall Completion Date: 07/09/2026

Directed Completion Date: *07/19/2026*

Implemented ([redacted] - 08/25/2026)

233d - Electronic/Magnetic System

13. Requirements

2600.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

On 6/3/2023 the doors providing access to the Skilled Nursing Unit, where the secure dementia residents have been temporarily relocated, were not secured by an electronic or magnetic locking system.

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. This was a temporary situation resulting from a sprinkler system failure in the Secured Dementia Care Unit on May 29, 2026, which required evacuation and relocation of residents to the skilled nursing side. Residents remained on the skilled nursing side from May 29, 2026 until June 3, 2026, before being moved to the former assisted living unit. The facility contracted with NEPPS to install magnetic lock doors in the former assisted living unit to secure the space. A certified letter, including certification of system installation and functionality, was emailed by NEPPS as proof that the work was completed. One-to-one staffing was assigned to sit at the doors from the time residents were moved to this space until the magnetic lock doors were completed and fully secured on June 5, 2026. Responsible: Governing Body/Administrator/Nursing/Maintenance/NEPPS. Completed: 06/05/2026

233d Electronic/Magnetic System (continued)

2. This was an isolated incident resulting from an unforeseen sprinkler system failure. Neither the skilled nursing side nor the former assisted living unit had electronic or magnetic locking doors readily in place at the time residents needed to be relocated, since these are not spaces normally used to house Secured Dementia Care Unit residents. The facility contracted with NEPPS to install magnetic lock doors in the former assisted living unit to secure the space. A certified letter, including certification of system installation and functionality, was emailed by NEPPS as proof that the work was completed. One to one staffing was assigned to sit at the doors from the time residents were moved to this space until the magnetic lock doors were completed and fully secured on June 5, 2026. Responsible: Governing Administrator/Nursing/Maintenance/NEPPS. Completed: 06/05/2026

3. One to one staffing coverage was assigned to sit at the doors of the temporary relocation space for the full duration until magnetic lock doors were installed and secured. Responsible: Administrator/Nursing/Maintenance. Completed: 06/05/2026

4. Residents currently reside in the former assisted living unit, which is now secured with magnetic locking doors, installed and certified by NEPPS. Should any future evacuation or emergency require residents to be temporarily relocated to an area that is not secured with an electronic or magnetic locking system, one to one staffing will be assigned to sit at the door(s) for the full duration of the displacement, to ensure resident safety and prevent elopement until the area is properly secured or residents can return to a properly secured area. Responsible: Administrator/Nursing. Ongoing.

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

236 - Staff Training

14. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person D, who works in the Secure Dementia Care Unit (SDCU) had only 3.5 hours of training in dementia care during the June 2025 to May 2026 training year.

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. Staff Member D will complete the remaining required SDCU dementia specific training hours to reach the full 6 hours required. Responsible: Administrator. Completion Date: 07/8/2026

236 - Staff Training (continued)

2. Staff Member D missed a scheduled month of training sessions during the training year, resulting in incomplete coverage of the required SDCU dementia-specific training hours for that training year. Adminstrator will be trained on this regulation. A monthly training attendance tracker was already implemented for the facility, which includes a dedicated section tracking the additional 6 hours of SDCU dementia-specific training separately from the base 12-hour annual topics. Any staff member who misses a scheduled SDCU training session will be flagged immediately and scheduled for make-up training within the same month. Responsible: Administrator. Completion Date: 07/8/2026

3. This citation is addressed through the same monthly training attendance tracker already implemented for the facility, which includes a dedicated section tracking the additional 6 hours of SDCU dementia-specific training separately from the base 12-hour annual topics. Any staff member who misses a scheduled SDCU training session will be flagged immediately and scheduled for make-up training within the same month. Responsible: Administrator. Completed: 07/8/2026

4. Administrator will conduct a monthly review of the training tracker's SDCU section to confirm all staff assigned to the Secured Dementia Care Unit are current on the full 18 required annual hours (12 base plus 6 SDCU-specific). Findings will be reviewed at monthly QAPI/QI meetings, using the same tracking and reporting process already in place for the facility's other training citations. Responsible: Administrator. Ongoing, beginning: 07/8/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)

252 - Record Content

15. Requirements

2600.

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

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.

252 - Record Content *(continued)*

13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident 1's record does not include initial Resident Assessment Support Plan.

Plan of Correction ***Accept (- 07/10/2026)***

1.The resident was admitted to the facility on . During the annual survey, the Administrator identified that the initial admission Resident Assessment Support Plan (RASP) could not be located in the resident's record. The Administrator conducted a search and was unable to locate the missing initial RASP; it cannot be retroactively recreated. The resident's most recent annual RASP has been confirmed complete, current, and signed, with the assessment and support plan finalized This was confirmed and attested to by the Administrator on 07/02/2026. Responsible: Administrator. Completed: 07/02/2026

2. This is the same resident record identified in the related medical evaluation citation. Multiple changes in Administrator since the resident's admission resulted in a gap in record review at the time of admission, during which the initial RASP was not confirmed present in the resident's file. Administrator was educated on this regulation on 7/2/2026.Responsible: Administrator. Completed: 07/02/2026

3.The admission checklist which was already implemented with the medical evaluation citation for the facility requires the Administrator to confirm the RASP is completed, signed, and filed in the resident's record within 30 days of admission, before the resident's record is considered finalized. Responsible: Administrator. Completed: 07/02/2026

4. This citation is addressed through the same periodic resident record audit with the Medical Evaluation information citation already implemented for the facility, which confirms all required record content, including the RASP, medical evaluation, and assessment, remains complete and on file. Findings will be reviewed at monthly QAPI/QI meetings, using the same tracking and admission checklist process already in place for the facility's other record-related citations. Responsible: Administrator. Ongoing, beginning: 07/02/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

252 Record Content *(continued)*

Implemented ([redacted] - 08/25/2026)

254b Policy and Procedures

16. Requirements

2600.
254.b. Each home shall develop and implement policy and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records.

Description of Violation

The home does not have policies and procedures for managing records.

Plan of Correction ***Accept ([redacted] - 07/10/2026)***

1. The facility had an existing records policy and procedure; however, it was unable to be located following the sprinkler system failure and evacuation on May 29, 2026, during which binders were displaced. The policy was located and confirmed on June 4, 2026, and has since been reissued with an effective date of April 14, 2026. Responsible: Governing Body/Administrator. Completed: 06/04/2026

2. The facility's records policy binder was displaced during the sprinkler system evacuation and was not located again until June 4, 2026, making it inaccessible during the period of the survey. Identified by: Administrator

3. The governing body is responsible for implementing and maintaining the facility's records policy and procedures. The reissued policy addresses record accessibility, security, storage (including a specific provision for emergency displacement of records), authorized use and release, and designation of responsibility for records. Responsible: Governing Body. Completed: 06/04/2026

4. The Administrator will confirm the records policy remains accessible and on file at all times, with the governing body reviewing the policy annually. Findings will be reviewed at monthly QAPI/QI meetings. Responsible: Governing Body/Administrator. Ongoing, beginning: 06/04/2026

Licensee's Proposed Overall Completion Date: *07/09/2026*

Implemented ([redacted] - 08/25/2026)