

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

September 23, 2026

[REDACTED]
HARRISBURG AL OPERATIONS LLC
[REDACTED]

RE: VIVA SENIOR LIVING AT
HARRISBURG
150 KEMPTON AVENUE
HARRISBURG, PA, 17111
LICENSE/COC#: 33805

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/03/2026, 06/04/2026 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: VIVA SENIOR LIVING AT HARRISBURG

License #: 33805

License Expiration: 07/01/2026

Address: 150 KEMPTON AVENUE, HARRISBURG, PA 17111

County: DAUPHIN

Region: CENTRAL

Administrator

Name:

Phone:

Email:

Legal Entity

Name: HARRISBURG AL OPERATIONS LLC

Address:

Phone:

Email:

Certificate(s) of Occupancy

Type: C-2 LP

Date: 10/31/1997

Issued By: Department of Labor and Industry

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 130

Waking Staff: 98

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Complaint, Interim

Exit Conference Date: 06/03/2026

Inspection Dates and Department Representative

06/03/2026 - On-Site:

06/04/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 96

Residents Served: 82

Secured Dementia Care Unit

In Home: Yes

Area: Sweet Memories

Capacity: 24

Residents Served: 13

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 82

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 48

Have Physical Disability: 1

Inspections / Reviews

06/03/2026 Partial

Lead Inspector:

Follow-Up Type: POC Submission

Follow-Up Date: 07/19/2026

Inspections / Reviews (*continued*)

07/24/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/31/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 07/31/2026

09/23/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/31/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

5a1 - DHS Access

1. Requirements

2600.

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

1. Agents of the Department.

Description of Violation

On [REDACTED], at 9:10am and 10:30am, an agent of the Department requested access to a staff list to include all staff, name, job title, dates of hire and contact information and resident list to include resident name, room number, date of admission and demographic information. On [REDACTED] at 12:00pm, Staff Member A provided the staff list with dates of hire and the resident list with dates of admission.

On [REDACTED] at 10:30am, and [REDACTED] at 12:30pm an agent of the Department requested access to the First Aid and CPR certifications from staff member A, which were not provided during the inspection.

On [REDACTED], at approximately 11:00am, an agent of the Department requested access to the state reportable incidents. On [REDACTED] at 3:30pm, Staff member A provided an internal incident report document listing various incidents.

On [REDACTED] at 1:10pm, an agent of the Department requested access to shower charts, to include refusals, or documentation the home maintains to document showers for last two weeks from Staff member B. However, the documentation was not provided during the inspection.

On [REDACTED], at 11:30am and [REDACTED] at 11:00am, an agent of the Department requested access to resident demographics in the home and number of residents with mobility needs in the home for the following dates: [REDACTED]
[REDACTED], and [REDACTED] Staff member A provided the documentation on [REDACTED] at 2:00pm.

5a1 DHS Access (continued)

Plan of Correction

Accept [REDACTED] - 07/24/2026)

There was no negative impact to resident care as a result of this deficiency. The requested staff list and documentation were provided to the survey agents following the facility walk through.

The ED reviewed the process for responding to requests for records and documentation to ensure that all required information can be located and provided promptly when requested by regulatory agencies.

The Administrator and/or designee will ensure that all requested records and documents are provided in a timely manner during surveys, inspections, and regulatory visits.

On June 8, 2026, the Administrator, Resident Care Director (RCD), and Business Office Manager (BOM) reviewed and reorganized the location of required documents to ensure that key information is readily accessible and that responsible staff know where all required records are maintained. Starting 6/23/2026, the Administrator or designee began audits 1x a month for 3 months to verify that required resident, personnel, and facility documents are properly organized, readily accessible, and available upon request. Audit results will be reviewed during the facility's monthly Quality Assurance Performance Improvement (QAPI) meetings. Any identified concerns will be addressed immediately, and additional staff education will be provided as needed.

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

Implemented [REDACTED] - 09/23/2026)

17 - Record Confidentiality

2. Requirements

2600.

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

Description of Violation

On [REDACTED] at 9:18am, the login and password was observed written on a paper note and taped to the laptop computer which was unattended and accessible sitting on top of the medication cart on the 2nd floor. The laptop is used to access the resident medication administration records, to include resident [REDACTED] medication administration record information such as 8:00am medications, [REDACTED] and [REDACTED]

Plan of Correction

Accept [REDACTED] - 07/24/2026)

: The issue was immediately corrected on June 3, 2026, when the medication technician removed the note containing the login credentials from the computer. No unauthorized access to resident information was identified.

A review of medication carts, medication rooms, and computers was conducted to ensure that no other login credentials or passwords were visibly posted. Any identified concerns would have been corrected immediately.

The Resident Care Director (RCD) provided education on 6/8/2026 to the medication technician regarding the importance of maintaining password confidentiality and ensuring that login credentials are not displayed in a conspicuous location that could lead to unauthorized access.

Beginning June 15, 2026, the Resident Care Director or designee began audits 1x a week for 2 months of

17 Record Confidentiality (continued)

medication rooms, medication carts, and computers to ensure that login credentials are not visibly posted and that staff remain compliant with confidentiality and security requirements. Audit findings will be documented, and any identified concerns will be addressed immediately with additional education as needed. Audit results will be reviewed at monthly Quality Assurance Performance Improvement (QAPI) meetings to ensure ongoing compliance.

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

Implemented [REDACTED] 09/23/2026)

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 [REDACTED], there were 69 residents in the home including 39 residents with mobility needs, and 4 residents requiring extra assistance of 2 staff members, requiring 112 service hours daily, and 84 service hours during waking hours. However, on this date, the home only provided 80.5 service hours daily and 54 hours during waking hours.

On [REDACTED], there were 72 residents in home including 38 residents with mobility needs, and 4 residents requiring extra assistance of 2 staff members, requiring 114 service hours daily, and 85.5 service hours during waking hours; however, the home only provided 67.5 service hours daily and 40.5 during waking hours.

On [REDACTED] there were 72 residents in home including 48 residents with mobility needs, and 5 residents requiring extra assistance of 2 staff members, requiring 125 service hours daily, and 93.75 service hours during waking hours; however, on this date, the home only provided 89.5 service hours daily and 67 during waking hours.

On [REDACTED], there were 70 residents in home including 37 with mobility needs, and 5 residents requiring extra assistance of 2 staff members, requiring 112 service hours daily, and 84 service hours during waking hours. However, on this date, the home only provided 65.5 hours daily and 49 during waking hours.

On [REDACTED] there were 70 residents in the home including 48 residents with mobility needs, and 5 residents requiring extra assistance of 2 staff, requiring 123 service hours daily, and 92.25 service hours during waking hours; however, the home only provided 85 hours daily and 66 during waking hours.

On [REDACTED], there were 81 residents in the home with 48 residents with mobility needs, and 5 residents requiring extra assistance from 2 staff members, requiring 134 service hours daily, and 100.5 service hours during waking hours. However, the home only provided 92.5 service hours and 70 services hours during waking hours.

57c 2 Hours/Day (continued)

Plan of Correction

Accept [REDACTED] - 07/24/2026)

On 6/5/2026, ED and RCD reviewed staffing schedules and staffing levels to ensure adequate coverage for resident care needs. Adjustments were made to staffing schedules as necessary to achieve compliance with state staffing requirements.

The Resident Care Director (RCD) was educated 6/9/2026 on the requirements for calculating staffing hours and ensuring compliance with state mandated staffing levels by ED. Going forward, the RCD will ensure that staffing hours are calculated accurately and that schedules are developed to meet or exceed required staffing standards. Starting June 10th 2026, the RCD or designee began staffing audits 1x every 2 weeks x3 months when schedules are prepared to verify compliance with state staffing requirements. Audit findings will be documented and reviewed during monthly Quality Assurance Performance Improvement (QAPI) meetings. Any identified concerns will be addressed immediately, and corrective action will be implemented as needed to maintain compliance.

Licensee's Proposed Overall Completion Date: 08/07/2026

Implemented [REDACTED] - 09/23/2026)

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 [REDACTED] a total of 112 hours of direct care was required. However, only 54 of the required hours, or 48% percent, were provided during waking hours.

On [REDACTED] a total of 114 hours of direct care was required. However, only 40.5 of the required hours, or 35% percent, were provided during waking hours.

On [REDACTED], a total of 125 hours of direct care was required. However, only 67 of the required hours, or 54% percent, were provided during waking hours.

On [REDACTED], a total of 112 hours of direct care was required. However, only 49 of the required hours, or 44% percent, were provided during waking hours.

On [REDACTED], a total of 123 hours of direct care was required. However, only 66 of the required hours, or 54% percent, were provided during waking hours.

On [REDACTED], a total of 134 hours of direct care was required. However, only 70 of the required hours, or 52% percent, were provided during waking hours.

57d - Waking Hours (continued)

Plan of Correction

Accept () - 07/24/2026)

On 6/5/2026, RCD reviewed staffing schedules and staffing levels to ensure adequate coverage for resident care needs. Adjustments were made to staffing schedules as necessary to achieve compliance with state staffing requirements.

The Resident Care Director (RCD) was educated on 6/9/2026 on the requirements for calculating staffing hours and ensuring compliance with state-mandated staffing levels by ED. Going forward, the RCD or designee will ensure that staffing hours are calculated accurately and that schedules are developed to meet or exceed required staffing standards.

Starting June 10th 2026, the RCD or designee began staffing audits 1x every 2 weeks x3 months when schedules are prepared to verify compliance with state staffing requirements. Audit findings will be documented and reviewed during monthly Quality Assurance Performance Improvement (QAPI) meetings. Any identified concerns will be addressed immediately, and corrective action will be implemented as needed to maintain compliance.

Licensee's Proposed Overall Completion Date: 08/07/2026

Implemented () - 09/23/2026)

63a - First Aid/CPR Training

6. Requirements

2600.

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

Description of Violation

On () from 3:00pm to 11:00pm, 81 residents were in the home. During this time only 1 staff member was certified in first aid and CPR and was present in the home.

On (), from 11:00pm to 7:00am, 81 residents were in home. During this time, only 1 staff member was certified in first aid and CPR and was present in the home.

On (), from 3:00pm to 11:00pm, 81 residents were in the home. During this time only 1 staff member was certified in first aid and CPR and was present in the home.

On (), from 11:00pm to 7:00am, 81 residents were in home. During this time, only 1 staff member was certified in first aid and CPR and was present in the home.

Repeated Violation: () et al.

Plan of Correction

Accept () - 07/24/2026)

The home was cited for not having a sufficient number of CPR-certified staff available in the building to meet regulatory requirements.

On 6/5/2026, The BOM reviewed current CPR certification records and staffing schedules to identify gaps in coverage and ensure resident safety. Immediate steps were taken to increase the number of CPR-certified staff available in the building.

A facility-wide review of employee certification records was conducted on 6/10/2026 to determine which staff

63a - First Aid/CPR Training (continued)

required CPR certification or recertification. Staff needing certification were identified and scheduled for training. Prior to the survey, the Business Office Manager (BOM) had already scheduled CPR training for June 15, 2026. A second CPR training session has been scheduled for July 20, 2026, to ensure all required staff obtain and maintain current CPR certification.

The BOM will continue to monitor certification expiration dates and schedule training as needed to maintain compliance with CPR certification requirements. Starting 6/15/2026, The BOM began audits 1x a month for x3 months of employee personnel files to verify that required certifications, including CPR certification, are current and maintained. Audit findings will be documented and reviewed during monthly Quality Assurance Performance Improvement (QAPI) meetings. Any identified deficiencies will be addressed immediately, and staff will be scheduled for training or recertification as needed.

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

Implemented [REDACTED] - 09/23/2026)

81b - Resident Personal Equipment**7. Requirements**

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On [REDACTED] at 2:06pm, the enabler bar installed on resident [REDACTED]'s bed was pulled approximately 6 inches away from the bed, posing an entrapment risk.

Repeated Violation: [REDACTED] et al., [REDACTED]

Plan of Correction

Accept [REDACTED] - 07/24/2026)

The issue was immediately addressed by the Director of Maintenance in collaboration with Physical Therapy from Fox Rehabilitation on June 4, 2026. The Director of Maintenance adjusted the bed enabler by trimming a portion of the padding designed to prevent sliding. The padding must be maintained at four inches to ensure proper fit, stability, and secure placement of the enabler bar.

A review of other resident beds with enablers was completed to ensure proper placement, secure installation, and compliance with safety requirements. Any identified concerns were corrected immediately.

Maintenance staff were educated on the proper placement and inspection requirements for bed enablers. Staff were instructed to ensure all assistive devices are properly secured and maintained according to manufacturer recommendations and safety standards.

Beginning June 8, 2026, the Director of Maintenance began audits 1x a week for 2 months of resident beds with enablers to verify proper placement, secure attachment, and compliance. Audit findings will be documented and reviewed. Any identified concerns will be corrected immediately, and additional education will be provided as needed.

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

Implemented [REDACTED] - 09/23/2026)

85a - Sanitary Conditions

9. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [REDACTED] at 10:07am, there was a live fly on a urine-soaked chucks pad on the bed in room [REDACTED], which is occupied by Resident [REDACTED]. There was also a fly in the shared bathroom within this bedroom. The bathroom had small brown/black pieces of unidentifiable matter stuck to various spots of the floor, the floor was sticky. There was a strong odor of feces in the room.

On [REDACTED] at 12:00pm resident room [REDACTED] occupied by Resident [REDACTED], smelled strongly of urine immediately upon opening the resident's room door. Staff Member I pointed to the resident's recliner when asked about the urine smell.

On [REDACTED] at 12:20pm, at least 4 green upholstered chairs in living room of SDCU contained stains, drips and visible dirty spots on the seats and arm rests.

On [REDACTED] at 12:00pm, the entire floor surface in the SDCU dining room and kitchenette area were very sticky causing shoes to be stuck to the floor and shoe marks were visibly left after each step.

Plan of Correction**Accept ([REDACTED] - 07/24/2026)**

Any identified concerns were corrected immediately on 6/3/2026. Housekeeping cleaned and sanitized the resident room and shared bathroom to remove odors, soiled areas, and any environmental concerns.

On June 8, 2026, resident room odors were further addressed by the Maintenance Director and Resident Care Director (RCD). Housekeeping completed additional cleaning of the SDCU kitchen floors using hot water to remove stickiness and ensure proper sanitation.

A review of resident rooms and common areas was completed to identify any additional concerns related to odors, cleanliness, or environmental conditions on 6/5/2026.

The Maintenance Director provided education to housekeeping and care staff on June 9, 2026, regarding the importance of timely room and bathroom cleaning, maintaining sanitary conditions, and promptly addressing spills, odors, and environmental concerns.

Care staff were instructed to check resident chairs and incontinence pads daily for saturation and ensure timely replacement as needed. SDCU chairs were cleaned, and the Maintenance Director/staff will shampoo resident chairs monthly to prevent odor buildup and maintain cleanliness. Starting 7/17/2026, the Maintenance Director and Resident Care Director will conduct environmental audits 1x a week for 3 months to monitor resident rooms, bathrooms, common areas, resident seating, and cleanliness standards. Audit results will be documented and reviewed during monthly Quality Assurance Performance Improvement (QAPI) meetings. Any identified concerns will be corrected immediately, and additional education will be provided as needed.

Licensee's Proposed Overall Completion Date: 07/31/2026**Implemented ([REDACTED] - 09/23/2026)****88a - Surfaces****10. Requirements**

2600.

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

88a Surfaces (continued)

Description of Violation

On [REDACTED] at 9:39am, above the baseboard outside room [REDACTED] there was a hole in the drywall, measuring approximately 3 inches long.

On [REDACTED] at 10:07am, the entire door handle and inner components of the handle on bedroom [REDACTED] door was loose and wiggled approximately half an inch in all directions.

On [REDACTED], the door of bedroom [REDACTED] was stuck and required additional force to open. The top of the door and door frame had scrapes missing from the metal frame and the door showed wear from rubbing on the frame.

On [REDACTED] at 12:18pm, the entire door handle and inner components of the handle on bedroom [REDACTED] door was loose and wiggled approximately half an inch in all directions.

Plan of Correction

Accept [REDACTED] - 07/24/2026)

The home was cited for environmental concerns in the SDCU, including a hole above the baseboard, a door that was stuck, and two door handles that were loose and not functioning properly.

The identified concerns were immediately addressed. On June 3, 2026, and June 4, 2026, the Maintenance Director repaired the hole in the wall, corrected the stuck door, and repaired both loose and jiggling door handles to ensure a safe and functional environment for residents.

A review of the SDCU and facility environment was completed to identify any additional maintenance concerns. Any issues identified were addressed promptly to maintain a safe and comfortable living environment.

The Resident Care Director (RCD) provided education on 6/11/2026 to staff regarding the importance of promptly reporting environmental and maintenance concerns as they are identified. Staff were reminded that timely reporting allows issues to be addressed before they impact resident safety or quality of life.

Starting 6/8/2026, The Maintenance Director and ED began daily thorough walk through inspections of the building to identify and address any maintenance concerns.

Beginning June 8, 2026, the Maintenance Director or designee began environmental audits 1x a week for 3 months to verify that building conditions remain safe, functional, and free of identified concerns. Audit results will be documented and reviewed during monthly Quality Assurance Performance Improvement (QAPI) meetings. Any identified issues will be corrected immediately, and additional education will be provided as needed.

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

Implemented [REDACTED] - 09/23/2026)

121a - Unobstructed Egress

12. Requirements

2600.

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

121a - Unobstructed Egress (*continued*)**Description of Violation**

On [REDACTED] at 10:30am the egress door leading from SDCU to the courtyard would not open. At 10:52am, staff member J attempted to open the door twice without success.

Plan of Correction

Accept [REDACTED] - 07/24/2026)

The Maintenance Director inspected the egress door on June 3, 2026. The door was tested and immediately opened properly. No further concerns were identified at that time.

A review of other facility egress doors was completed on 6/5/2026 to ensure doors were functioning properly and accessible for safe evacuation. Any concerns identified were addressed immediately.

The Maintenance Director will monitor all egress doors to ensure they remain operational, accessible, and free of issues that could prevent safe opening. Staff were reminded to report any concerns related to doors or building safety immediately.

Beginning June 8, 2026, the Maintenance Director or designee began checks 1x a week for 3 months of the egress door to ensure the door opens easily and safely and is not sticking or creating an obstruction. Audit results will be documented and reviewed during monthly Quality Assurance Performance Improvement (QAPI) meetings. Any identified concerns will be corrected immediately.

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

Implemented [REDACTED] - 09/23/2026)

141a 1-10 Medical Evaluation Information

14. 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 [REDACTED] medical evaluation dated [REDACTED] does not include the type of evaluation completed, the advance directives section was not completed and the medical professional information states "the residents needs CAN NOT be met safely at the personal care."

Plan of Correction

Accept [REDACTED] - 07/24/2026)

Resident [REDACTED] financial admission date was May 29, 2026, and the resident physically moved into the community on June 2, 2026. DME dated May 27, 2026, was completed and maintained in the resident's record prior to admission. After admission, the resident's primary care provider identified an error on the original DME and completed a corrected DME on June 11, 2026. The corrected DME was obtained immediately and placed in the resident's

141a 1-10 Medical Evaluation Information (continued)

medical record.

Resident ■■■'s DME dated August 6, 2025, was found to contain incomplete and inaccurate information, including the omission of the type of evaluation completed, an incomplete Advance Directives section, and documentation indicating the resident's needs could not be safely met in a personal care home. Upon identification, the resident's primary care provider completed a corrected DME on June 5, 2026. The corrected DME includes all required information and has been placed in the resident's medical record.

On 6/8/2026, The Executive Director and Resident Care Director reviewed admission procedures to ensure all required DME'S are complete, accurate, and signed by the primary care provider prior to admission whenever required by regulation. Starting 6/8/2026, the Executive Director or designee will audit 100% of all new admissions and updated DME'S for completeness and accuracy prior to or immediately upon admission 1x a month for 3 months, as applicable. Audit results will be reviewed monthly at Quality Assurance/Performance Improvement (QAPI) meetings. Any deficiencies identified during audits will be corrected promptly, and additional staff education will be provided as needed.

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

Implemented ■■■ - 09/23/2026)

183b - Meds and Syringes Locked**16. Requirements**

2600.

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

Description of Violation

On ■■■ at 12:00pm, calmoseptine ointment was observed on Resident ■■■'s nightstand. Resident ■■■ is not assessed to self-administer this medication.

Plan of Correction

Accept ■■■ - 07/24/2026)

On June 4, 2026, at 12:00 p.m., Calmoseptine ointment was observed on Resident ■■■ nightstand. The ointment was immediately removed and secured in the medication cart. On 6/4/2026, the resident's medication management plan was reviewed to ensure medications are prescribed and administered by the right licensed personnel and stored in accordance with physician orders and facility policy.

On 6/8/2026, a facility-wide audit was conducted by the RCD to identify any other residents with medications stored at the bedside who were not authorized to self-administer.

Licensed nursing staff and medication technicians were re-educated on 6/11/2026 on medication storage requirements, including the requirement that medications may only be kept at the bedside when authorized by physician order and when the resident has been assessed and approved to self-administer medications.

Starting 6/15/2026, the Resident Care Director or designee began storage audits 1x a week for the next 3 months to ensure compliance with medication administration and storage requirements. Audit findings will be reviewed during the monthly Quality Assurance and Performance Improvement (QAPI) meetings, and additional corrective action will be taken as needed.

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

Implemented ■■■ - 09/23/2026)

183e Storing Medications

17. 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 [REDACTED] is prescribed [REDACTED] three times a day with meals. On [REDACTED], the [REDACTED] was labeled with an open date of [REDACTED]. The manufacturer's instructions indicate the expiration date for the medication is 28 days after opening.

Repeated Violation: [REDACTED] et al., [REDACTED]

Plan of Correction

Accept [REDACTED] - 07/24/2026)

The expired [REDACTED] was immediately removed from the medication cart and discarded on June 4, 2026, in accordance with manufacturer guidelines and facility policy. A new [REDACTED] was obtained and placed into service the same day. The replacement medication was properly labeled with the date opened to ensure compliance with the manufacturer's beyond-use requirements.

On June 10, 2026, the Resident Care Director completed an audit of all medication carts to verify that medications were within their labeled expiration dates, including manufacturer-designated beyond-use dates for insulin pens and other multi-dose medications. No additional expired medications were identified. Licensed nursing staff were re-educated on 6/11/2026 on proper medication storage, dating of multi-dose medications upon opening, and routine monitoring of expiration and beyond-use dates in accordance with manufacturer recommendations and facility policy.

The Resident Care Director or designee on 6/10/2026 began medication cart audits 1 x a week for 4 weeks, followed by monthly audits for 3 months, to verify that all medications, including insulin pens and other multi-dose medications, are appropriately dated and have not exceeded their expiration or beyond-use dates. Any discrepancies identified will be corrected immediately, and additional staff education will be provided as necessary. Audit findings will be reviewed at Quality Assurance/Performance Improvement (QAPI) meetings.

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

Implemented [REDACTED] - 09/23/2026)

190a Completion Medication Course

23. Requirements

2600.

190.a. A staff person who has successfully completed a Department approved medications administration course that includes the passing of the Department's performance based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Member B, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include Resident [REDACTED]:

On [REDACTED] and [REDACTED] at 8:00am, [REDACTED] for [REDACTED].

On [REDACTED] and [REDACTED] at 8:00am, [REDACTED] for [REDACTED].

190a - Completion Medication Course (continued)

On [REDACTED] at 9:17am, [REDACTED] for [REDACTED]

Staff Member C, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include resident [REDACTED]:

On [REDACTED] at 5:00pm, [REDACTED] for [REDACTED]

On [REDACTED] at 5:00pm, [REDACTED] for [REDACTED]

Staff Member E, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include resident [REDACTED]

On [REDACTED] and [REDACTED] at 8:00am, [REDACTED] for [REDACTED].

On [REDACTED] at 8:00am, [REDACTED] tablet for [REDACTED]

On [REDACTED] at 8:00am, [REDACTED] tablet for [REDACTED].

Staff Member F, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include Resident [REDACTED]

On [REDACTED] at approximately 9:40am –

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

Staff Member H, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include resident [REDACTED]

On [REDACTED] and [REDACTED] at 8:00pm, [REDACTED] for [REDACTED]

On [REDACTED] and [REDACTED] at 8:00pm, [REDACTED] for [REDACTED]

On [REDACTED] and [REDACTED] at 8:00pm, [REDACTED] for [REDACTED]

Staff Member J, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include resident [REDACTED]

On [REDACTED] and [REDACTED] at 5:00pm, [REDACTED] for [REDACTED].

On [REDACTED] at 8:00pm, [REDACTED] for [REDACTED].

Plan of Correction

Accept [REDACTED] 07/24/2026)

Upon identification of the deficiency, the Resident Care Director (RCD) reviewed medication technician training documentation on 6/5/2026, to ensure all medication technicians had completed the required training and competency requirements prior to administering medications.

On June 8, 2026, all medication technician competency scores were printed and placed in each employee's personnel file to verify completion and maintain documentation of competency. This review ensured that all medication technicians assigned to administer medications had the required documentation available and met the community's requirements.

As a systemic corrective measure, the Resident Care Director will verify that all newly hired and current medication technicians have completed all required training, competency testing, and documentation prior to administering medications to residents. Required paperwork will be reviewed and maintained in employee files before medication administration privileges are granted.

190a Completion Medication Course (continued)

The Resident Care Director or designee began audits of medication technician training files starting 6/13/2026, 1x a month for 3 months to ensure documentation remains current and complete. Audit results will be reviewed during Quality Assurance and Performance Improvement (QAPI) meetings, and any identified concerns will be addressed immediately.

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

Implemented [REDACTED] 09/23/2026)

225a - Assessment 15 Days**25. Requirements**

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident [REDACTED], who was admitted to the home on [REDACTED]

Resident [REDACTED] assessment, signed [REDACTED] does not include the date the assessment was finalized.

Plan of Correction

Accept [REDACTED] - 07/24/2026)

On 6/8/2026, the Resident Assessment Support Plan (RASP) for resident [REDACTED] was reviewed and verified as completed and maintained within the resident's electronic medical record. A copy of the completed assessment was printed and placed in the resident's paper chart to ensure all required documentation is readily available and accessible for review.

The resident assessment for Resident # [REDACTED], was reviewed and corrected to include the finalized assessment date of April 28, 2026. The corrected assessment was placed in the resident's record to ensure the documentation accurately reflects the completed assessment process.

To identify any additional concerns, the Resident Care Director or designee completed an audit on 6/19/2026 of resident assessments to verify that required assessments are completed, dated appropriately, and maintained within the resident's records. Any discrepancies identified were corrected immediately.

On 6/19/2026, staff responsible for completing and maintaining resident assessments were re educated by RCD on the importance of ensuring assessments are completed timely, finalized with accurate dates, and maintained in accordance with regulatory requirements and community policy.

Starting 6/19/2026, The Resident Care Director or designee began audits of resident assessments 1x a month for 3 months to ensure continued compliance. Audit results will be reviewed during the monthly Quality Assurance and Performance Improvement (QAPI) meetings, and additional corrective action will be implemented as needed.

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

Implemented [REDACTED] - 09/23/2026)