

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

October 6, 2026

[REDACTED], PARALEGAL
LCS BELLINGHAM TENANT LLC
[REDACTED]
[REDACTED]

RE: BELLINGHAM AT WEST CHESTER
1615 EAST BOOT ROAD
WEST CHESTER, PA, 19380
LICENSE/COC#: 15199

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/09/2026, 06/10/2026 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: BELLINGHAM AT WEST CHESTER

License #: 15199

License Expiration: 05/30/2027

Address: 1615 EAST BOOT ROAD, WEST CHESTER, PA 19380

County: CHESTER

Region: SOUTHEAST

Administrator

Name:

Phone:

Email:

Legal Entity

Name: LCS BELLINGHAM TENANT LLC

Address:

Phone:

Email:

Certificate(s) of Occupancy

Type: / 1

Date: 02/21/2008

Issued By: East Goshen Township

Type: / 2

Date: 05/04/2023

Issued By: East Goshen Township

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 77

Waking Staff: 58

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal

Exit Conference Date: 06/10/2026

Inspection Dates and Department Representative

06/09/2026 On Site:

06/10/2026 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 80

Residents Served: 52

Secured Dementia Care Unit

In Home: Yes

Area: Memory Care

Capacity: 24

Residents Served: 15

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 52

Diagnosed with Mental Illness: 0

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 25

Have Physical Disability: 0

Inspections / Reviews

06/09/2026 - Full

Lead Inspector:

Follow Up Type: POC Submission

Follow Up Date: 07/12/2026

Inspections / Reviews (*continued*)

07/16/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/31/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 07/21/2026

07/21/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/31/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/02/2026

10/06/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/31/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

26a - Quality Management Plan

1. Requirements

2600.

26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home has not implemented its Quality Management Plan as it has no documentation of quality management reviews being completed. According to the home's Quality Management Plan, "Quality Management reviews will be conducted at least quarterly and more frequently when trends, incidents, complaints, licensing findings, resident needs, or operational changes indicate a need for additional review. A summary of findings, action steps, assigned responsibility, target dates, and follow-up outcomes will be documented for each review period."

Plan of Correction

Accept () - 07/16/2026)

The Executive Director will immediately establish a written quarterly quality management meeting schedule for the remainder of the calendar year. Quarterly quality management meetings will be held on the 15th day of the middle month of each quarter, beginning August 15, 2026. The schedule will include meeting dates, required attendees, agenda items, and documentation requirements. The first corrective quality management meeting will be held on August 15, 2026. During each quarterly quality management meeting, the home will review and evaluate, at minimum, reportable incident and condition reporting procedures, complaint procedures, staff training, licensing violations and plans of correction, and resident or family council feedback, if applicable. Any identified areas needing improvement will be assigned corrective measures, responsible parties, and target completion dates. The Executive Director will maintain a quality management binder containing the quarterly meeting schedule, agendas, sign-in sheets, meeting minutes, identified concerns, corrective actions, responsible parties, completion dates, and follow-up documentation.

The Executive Director will review the quality management file monthly for six months to ensure meetings are scheduled, held, and documented timely. After six months of compliance, the file will be reviewed quarterly as part of the ongoing quality management process.

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

Implemented () - 10/06/2026)

65e - 12 Hours Annual Training

2. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct Care Staff Person A received only 9.25 hours of annual training in training year 1/1/2025 through 12/31/2025.

Direct Care Staff Person B received only 5.25 hours of annual training in training year 1/1/2025 through 12/31/2025.

Repeat Violation: 9/18/2025

Plan of Correction

Accept () - 07/21/2026)

The business office manager audited current employee files the week of 6/22, and self identified any training missed and attached addendums. Some were completed during a re-orientation. The community will implement a

65e 12 Hours Annual Training (continued)

centralized annual training tracking system for all direct care staff persons by July 2026. The tracking system will include each staff person's name, hire date, required annual training hours, completed training hours, remaining hours due, required topics, documentation status, and due dates. The tracking system will be reviewed monthly by the Business Office Manager to ensure staff remain on schedule to complete annual training requirements before the end of each training year.

Direct care staff persons who are not on track to meet annual training requirements will be notified in writing and assigned specific training modules or in service sessions with completion deadlines. The schedule will be adjusted as needed to allow staff to complete training without disrupting resident care. No annual training file will be considered complete unless supporting documentation is present and verified. The Executive Director will conduct monthly audits of direct care staff training records for six months and quarterly thereafter to verify compliance with annual training requirements. Audit results will be documented and reviewed during the community's quality assurance or leadership meeting. Any identified deficiency will be corrected promptly, and follow up documentation will be maintained.

Because this is a repeat violation, the Business Office Manager will also review the previous corrective action related to the 9/18/2025 violation to determine why the prior process did not prevent recurrence. The revised tracking and audit process will be incorporated into the community's ongoing compliance oversight to ensure sustained correction.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026)

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

Direct Care Staff Person A did not receive training in medication self administration training, and/or instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 1/1/2025 through 12/31/2025.

Direct Care Staff Person B did not receive training in medication self administration training, and/or instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 1/1/2025 through 12/31/2025.

65f - Training Topics (continued)

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

The business office manager audited current employee files the week of 6/22, and self identified any training missed and attached addendums. The community will update its staff training tracking process to include a required annual review of medication self-administration training and resident-specific needs training for all direct care staff. The training tracker will identify required topics, due dates, completion dates, trainer, and documentation location. The Business Office Manager will review direct care staff training records monthly for three months, and then quarterly thereafter, to ensure required annual training is completed and documented within the applicable training year. Results of the audits will be documented on a training audit log. Any missing or incomplete training documentation will be corrected promptly, and staff will not be considered compliant until the required training documentation is complete

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026)

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 Person A 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, and/or emergency preparedness procedures and recognition and response to crises and emergency situations during training year 1/1/2025 through 12/31/2025.

Staff Person B 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, and/or falls and accident prevention during training year 1/1/2025 through 12/31/2025.

Plan of Correction**Accept () - 07/16/2026)**

Bellingham at West Chester will ensure that all staff receive appropriate fire safety training in accordance with PA Chapter 2600.65(g). A mandatory all-staff meeting will be held on July 15, 2026. During this meeting, the new Plant Director, who is fire safety certified, will review fire safety expectations, emergency procedures, staff responsibilities, and the required response during a fire or fire drill. Effective immediately, the Plant Director will conduct an

65g Annual Training Content (continued)

in person fire safety walkthrough with all newly hired employees during orientation. This walkthrough will include the location of fire exits, evacuation routes, fire extinguishers, pull stations, alarm panels as applicable, designated meeting areas, and staff responsibilities during an emergency. Fire safety training will also be completed annually for all employees. Any employee who is unable to attend the July 15, 2026 all staff meeting or any future required fire safety training will be identified by the Business Office Manager. The Business Office Manager will maintain a current training roster and will notify the Plant Director of any staff members who require make up training. The Plant Director will then provide individual or small group make up training, including the in person fire safety walkthrough, before the employee is permitted to work independently when possible. The Plant Director is responsible for providing fire safety training, orientation walkthroughs, annual trainings, and make up trainings. The Business Office Manager is responsible for tracking staff completion, identifying employees who missed training, maintaining documentation, and reporting outstanding training needs to the Plant Director. The Executive Director will provide oversight to ensure completion and compliance. Training attendance and completion records will be reviewed monthly by the Business Office Manager and Plant Director to ensure all employees remain current with fire safety training requirements. Any missed or overdue training will be addressed promptly through scheduled make up training. Documentation of all completed trainings and walkthroughs will be maintained and made available for review as needed.

Licensee's Proposed Overall Completion Date: 07/10/2026

Implemented (█ - 10/06/2026)

85a - Sanitary Conditions**5. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 6/10/2026:

- at 9:30 AM, there was urine on the floor next to the toilet in room A304.
- at 9:50 AM, there were feces on the toilet seat and bowl in room A208.

Plan of Correction

Accept (█ - 07/21/2026)

All rooms cited during the inspection were cleaned immediately to ensure sanitary conditions were restored. Maintenance assessed the toilet in A304 and began corrective repairs. The toilet is being replaced on 7/22, and the affected flooring is also being replaced to address any residual impact from the leak and to support ongoing sanitation. The condition in A304 was caused by a plumbing leak from the toilet. The leak resulted in fluid on the bathroom floor and created the appearance of unsanitary conditions. The issue required both cleaning and maintenance intervention. The community will maintain sanitary conditions by strengthening daily room observations, timely reporting of maintenance concerns, and follow up verification after repairs are completed. Direct care, housekeeping, and maintenance staff will report any evidence of leaks, wet flooring, odors, soiled bathroom areas, or other sanitation concerns immediately to the supervisor on duty and maintenance. Housekeeping or assigned staff will clean affected areas immediately when sanitation concerns are identified. Maintenance will assess reported leaks or plumbing concerns as soon as possible and will document the corrective action taken. When a leak or plumbing issue affects flooring or surrounding surfaces, maintenance will evaluate whether additional repair or replacement is needed.

85a - Sanitary Conditions (continued)

The Housekeeping supervisor will conduct follow-up checks to confirm that the area has been cleaned, repairs are in progress or completed, and sanitary conditions have been restored. Care staff to do daily checks and report to housekeeping immediately if any attention is needed effective immediately.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026)

91 - Telephone Numbers**6. Requirements**

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in room A208.

Plan of Correction

Accept () - 07/21/2026)

The Move-In Coordinator completed an audit of all apartments to verify whether the required emergency telephone numbers were posted on or by each telephone with an outside line the week of June 29th. Any apartment found to have a missing phone number, had the numbers added by the week of July 6th. The Move-In Coordinator will be responsible for verifying that the required emergency telephone numbers are posted on or by each telephone with an outside line at the time of move-in, effective immediately. This requirement will be added to the move-in checklist to ensure completion is documented before or at the time the resident occupies the apartment. Monthly spot checks will be completed to verify continued compliance in resident apartments.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026)

103i - Outdated Food**7. Requirements**

2600.

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

Description of Violation

There were unlabeled, undated packages of meat in the walk-in refrigerator, and an open, undated, unlabeled bag of fries in the walk-in freezer.

Plan of Correction

Accept () - 07/21/2026)

The unlabeled and undated packages of meat and the open, undated, and unlabeled bag of fries were removed from the walk-in freezer and discarded immediately. The walk-in freezer was inspected for any additional unlabeled, undated, opened, outdated, or questionable food items, and any items not meeting storage requirements were removed. The Dining Services Director to document weekly audits for four weeks beginning the week of 6/15 to verify that all food items in the walk-in freezer and food storage areas are properly labeled and dated and that no outdated, spoiled, or questionable food is present. Any concern identified during an audit will be corrected immediately. Audits continued until sustained compliance. The Executive Director will review audit results to ensure

103i - Outdated Food (continued)

continued compliance.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026

105g - Lint Removal and Duct Cleaning**8. Requirements**

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 6/10/2026, there was lint and paper in the lint trap of the first-floor laundry room. There were no clothes in the dryer at the time.

Plan of Correction

Accept () - 07/21/2026

The lint and paper were removed from the lint trap immediately upon identification. The dryer drum and surrounding area were checked to ensure no additional lint, paper, or debris was present. Staff responsible for laundry was reeducated that lint, paper, and debris must be removed from the lint trap and dryer drum after each use on 6/15. Staff will also be reminded to check the lint trap even when no clothing remains in the dryer, as the dryer must be left clean and free of lint or debris after use. The Housekeeping supervisor will complete routine checks of the laundry rooms to verify that lint traps are clean and free of debris weekly beginning week of 6/15 and continue as needed until full compliance is established.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026

107d - Procedure Emergency Management Agency Submission**9. 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 were submitted on 4/20/2026; they were previously submitted on 3/4/2025.

Plan of Correction

Accept () - 07/16/2026

The Executive Director will maintain an annual emergency preparedness compliance calendar that includes the required review, update, and submission of written emergency procedures to the local management agency. The due date will be scheduled for at least 30 days prior to the annual deadline to allow sufficient time for review, revision, and submission. Ongoing monitoring will be immediately and continue annually.

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

Implemented () - 10/06/2026

130f - Testing Smoke Detectors**10. Requirements**

130f Testing Smoke Detectors (continued)

2600.

130.f. Smoke detectors and fire alarms shall be tested for operability at least once per month. A written record of the monthly testing shall be kept.

Description of Violation

The home's smoke detectors and fire alarms were not tested during the month of 6/2025, 8/2025, 9/2025, 10/2025, 11/2025, 12/2025, 1/2026, 3/2026, and 5/2026.

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

On 6/17/26, the facility completed a fire alarm test with the alarms sounding to verify operability of the audible fire alarm system. The alarm company was notified and instructed that silent fire alarm testing is not to be completed for monthly fire alarm operability testing going forward on 6/10/26. The Maintenance Director will ensure that the monthly fire alarm operability test includes activation of the audible alarm system, effective immediately. The facility's monthly fire drill/fire alarm log will be updated to clearly document whether the audible alarm sounded, the date and time of testing, staff completing the test, and any corrective action needed, effective immediately. If the fire alarm system does not sound or is found to be inoperative, the facility will immediately implement emergency procedures and ensure repair is completed within required timeframes.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026)**132a Monthly Fire Drill****11. Requirements**

2600.

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

Description of Violation

An unannounced fire drill was not held during the months of 6/2025, 8/2025, 9/2025, 10/2025, 11/2025, 12/2025, 1/2026, 3/2026, and 5/2026.

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

Crocker Fire Safety was contacted on 6/10/26 regarding the citation and the community's fire drill process. Effective immediately, every fire drill will include activation of the fire alarm system. A fire drill was completed on 6/17/2026 at 11:28pm, during which the alarm was sounded. Maintenance Director to maintain a monthly fire drill compliance log to ensure a drill is completed each month, effective immediately. The calendar will identify the monthly drill requirement, ensure drills occur on varied days and times, and confirm the fire alarm system is activated during each drill. Fire drill documentation will be completed immediately after each drill and maintained with the fire safety records. Executive Director to review the fire drill compliance and completed fire drill records for six months beginning June 2026 to verify that an unannounced fire drill is completed each month and that the alarm is sounded during each drill.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026)

132b Safety Inspection/Fire Drill**12. Requirements**

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection observed by a fire safety expert was conducted on 9/26/2024.

Plan of Correction**Accept () - 07/16/2026)**

Upon identification of the missed annual requirement, executive director arranged for a fire and safety expert to conduct the required fire safety inspection. The fire safety expert came to the community 7/8/2026 at 9:30am to complete the inspection. The community is currently awaiting the finalized written letter/documentation from the safety expert and will maintain it with the fire safety records upon receipt. Executive Director will review the fire safety compliance calendar monthly for 6 months and then quarterly thereafter to ensure the annual fire safety expert inspections remain current.

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

Implemented () - 10/06/2026)**132d Evacuation****13. Requirements**

2600.

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

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills: 2/9/2026 at 4:43 PM, evacuation time 7 minutes 33 seconds and 4/20/2026 at 10:00 AM, evacuation time 9 minutes.

Plan of Correction**Accept () - 07/16/2026)**

On 7/8/2026 a fire safety expert came to the community to complete the inspection and review related to the safe evacuation time. The fire safety expert will provide written documentation of the inspection and a letter specifying the safe evacuation time for the building. Upon receipt, the documentation and letter will be maintained with the community's fire safety records and made available for review. The Maintenance Director will audit the fire safety documentation monthly for three months and then quarterly thereafter to ensure the written safe evacuation time remains current and is renewed annually by a fire safety expert who is not a staff person of the home. Maintenance set up reminder in TELS system for annual testing.

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

Implemented () - 10/06/2026)**132e Fire Drill Sleeping Hours****14. Requirements**

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

132e Fire Drill Sleeping Hours (*continued*)**Description of Violation**

The last fire drill conducted during sleeping hours was prior to 6/17/2025.

Plan of Correction

Accept () - 07/21/2026)

A fire drill was completed during sleeping hours on 6/17/2026 at 11:28 p.m. to correct the deficiency and ensure compliance with the required 6 month timeframe. The fire drill record will be maintained with the community's fire safety records and will include the date, time, amount of time it took to evacuate, exit route used, number of residents in the home at the time of the drill, number of residents evacuated, number of staff participating, problems encountered, and whether the fire alarm or smoke detector was operative, effective immediately. The Maintenance Director will maintain a fire drill tracking calendar that identifies the required monthly fire drills and specifically flags the required sleeping hours fire drill due every 6 months. The calendar will be reviewed monthly beginning June 2026, to confirm that drills are scheduled and completed within the required timeframes, while remaining unannounced to staff and residents.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026)

171b5 - First Aid Kit

15. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The car used to transport residents does not include a first aid kit.

Plan of Correction

Accept () - 07/16/2026)

A first aid kit was immediately added to the vehicle to correct the deficiency. The kit will be maintained in the vehicle and will include the required contents, including nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings, and tweezers. The Activities Department will be responsible for checking the vehicle first aid kit weekly for the next three months beginning 6/24/2026 to ensure the kit remains present, accessible, and stocked with all required contents. Any missing or expired items will be replaced immediately. Quarterly checks after the first three months.

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

Implemented () - 10/06/2026)

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 6/10/2026 at 10:07 AM, Polmyxin B tmp eye drops, Ketoconazole 2% cream and fluocinolone acetonide oil 0.01% ear drops were unlocked, unattended, and accessible in room A203.

183b Meds and Syringes Locked (continued)**Plan of Correction****Accept () - 07/21/2026)**

The medications identified were immediately secured in a locked medication storage area/container upon discovery. The area was checked to ensure no additional medications or medical supplies were left unlocked, unattended, or accessible. Staff on duty were immediately reminded that all prescription medications, topical medications, eye drops, over the counter medications, complementary and alternative medications, and syringes must remain locked when not being administered or actively supervised. Staff were re educated on 6/17/26 that medications may not be left unattended or accessible at any time and must be returned to a locked medication cart, locked medication room, locked cabinet, or other approved locked container immediately after use. The Health Services Assistant will conduct weekly storage audits beginning week of 6/15/26 to verify medications are locked when not in use effective immediately.

Licensee's Proposed Overall Completion Date: 07/21/2026**Implemented () - 10/06/2026)****183d - Prescription Current****17. Requirements**

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 6/10/2026, Xarelto 15 mg tabs prescribed to Resident 1, were in the home's 2nd floor medication cart; however, this medication is not listed on Resident 1's current medication orders.

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

The Xarelto 15 mg tablets were immediately removed from active medication storage and secured for review. The resident's current medication orders and medication administration record were reviewed to verify that Xarelto 15 mg was not an active order. The pharmacy and prescribing practitioner were contacted on 6/10/26, as applicable, to confirm the resident's current medication regimen and determine whether the medication was discontinued, sent in error, or required a new order. Effective immediately, the Health Services Assistant will perform weekly medication cart audits to identify any medications in the cart that do not have a current physician order or that belong to residents who have been discharged beginning 6/22/26. Any medication without a current order or belonging to a discharged resident will be removed from active storage immediately and handled according to the community's medication disposal/return process and applicable regulatory requirements. Medication administration staff and applicable direct care staff were re educated on 55 Pa. Code Chapter 2600.183(d) on 6/17/26, including the requirement that only current medications with active orders may be kept in the home. Education will include the expectation that staff compare medications received from the pharmacy with the current medication orders and medication administration record, report discrepancies immediately, and do not administer any medication that is not supported by a current order.

Licensee's Proposed Overall Completion Date: 07/21/2026**Implemented () - 10/06/2026)****183e - Storing Medications****18. Requirements**

2600.

183e Storing Medications (continued)

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 6/10/2026:

- the blister pack for Resident 1's prescribed Potassium Cl ER 10 meq tab was punctured at spot 15; the tablet was still in the pack.
- the blister pack for Resident 2's prescribed quetiapine fumarate 25mg tab was punctured at spot 5; the tablet was still in the pack.

Plan of Correction

Accept () - 07/21/2026

Upon identification of the punctured blister packs, the medication packages were removed from active use and reviewed by the medication tech to ensure the integrity of the medication supply. The pharmacy was contacted for guidance and replacement packaging as needed on 6/10/26. The affected residents' medication administration records were reviewed to confirm that the medications had not been administered from compromised packaging and that no medication error occurred. All current medication carts and medication storage areas were audited to identify any additional punctured, opened, damaged, or otherwise compromised blister packs immediately. Any medication package found to be compromised will be removed from use immediately, secured according to community policy, and reported to the pharmacy for replacement or direction. Medication staff was re educated that medications must remain in intact manufacturer/pharmacy packaging until the time of administration and that staff may not puncture, open, manipulate, or otherwise compromise blister packaging before the scheduled medication pass on 6/17/26. The Health Services Assistant will conduct weekly audits beginning 6/22/26 of medication carts and medication storage areas for four weeks, until sustained compliance is demonstrated, to confirm that all blister packs remain intact, organized, and stored appropriately.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026

185a - Implement Storage Procedures**19. Requirements**

2600.

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

Description of Violation

The following glucometer readings for Resident 3 were incorrectly documented in the resident's 6/2026 medication administration record (MAR):

- 6/3/2026, 4:36 PM, a glucometer reading of 236 was documented as 238 in the MAR.
- 6/4/2026, 6:38 PM, a glucometer reading of 201 was documented in the MAR, however there was not a reading in the glucometer for that date and time.
- 6/8/2026, 4:26 PM, a glucometer reading of 251 was documented as 152 in the MAR.

Repeat Violation: 9/18/2025

185a - Implement Storage Procedures (continued)

Plan of Correction

Accept () - 07/21/2026)

The Director of Health Care Services reviewed Resident 3's glucometer history and June 2026 MAR to identify and correct the documentation discrepancies. The corrected readings were documented in accordance with facility procedure, and the resident's physician/designee was notified of the discrepancies as applicable to determine whether any further clinical follow-up was needed. Resident 3 was assessed, and no adverse outcome was identified related to the documentation errors. The facility determined that the discrepancies were related to staff failure to accurately transcribe and verify glucometer readings against the glucometer result before documenting in the MAR. The facility also identified the need to reinforce expectations for real-time documentation and verification of blood glucose results. The Director of Health Care Services re-educated all medication administration staff on the facility's medication and medical equipment documentation procedures, including accurate documentation of glucometer results, confirming the reading in the glucometer before entering it into the MAR, documenting results at the time obtained, and immediately reporting any discrepancy or inability to verify a reading to the supervisor prior to completing documentation on 6/17/26. The Health Services Assistant will audit glucometer readings against the MAR for all residents receiving blood glucose monitoring to ensure readings are accurately documented. Audits will be completed weekly beginning week of 6/22 until sustained compliance is demonstrated. Any discrepancy identified during audits will be corrected promptly, reviewed with the staff member involved, and reported to the Executive Director for follow-up.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026)

187a - Medication Record

20. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident 3 is prescribed Novolog 100 unit/ml flexpen 100 ml. Per sliding scale: Inject 2 units sub-q with meals three times daily in addition to per sliding scale BS 141-180 additional 2 units, BS 181-220 additional 4 units, 221-260 additional 6 units, 261 -300 additional 8 units, 300-350 additional 10 units, greater than 350 call provider. This medication was administered on the following dates and times; however, the additional units administered per sliding scale is not included on Resident 3's 6/2026 medication administration record (MAR):

- 6/1, 6:46 PM, 2 units administered, Blood Sugar 163, per sliding scale 2 additional units should have been administered.
- 6/2, 7:37 AM, 2 units administered, Blood Sugar 151, per sliding scale 2 additional units should have been administered.
- 6/3, 4:39 PM, 2 units administered, Blood Sugar 238, per sliding scale 6 additional units should have been administered.
- 6/8, 4:25 PM, 2 units administered, Blood Sugar 251 in glucometer, documented as 152 in MAR, per sliding scale 6 additional units should have been administered.

187a Medication Record (continued)

Plan of Correction

Accept () - 07/21/2026

The medication record was reviewed immediately to identify the missing or incomplete information related to the citation. The record was corrected to the extent possible and reviewed by the appropriate supervisory staff to ensure all required medication record components are present and accurate going forward. A reportable was also completed in accordance with reporting requirements on 6/11/26. Medication administration staff was re educated on 6/17/26 on the requirements of 55 Pa. Code § 2600.187(a), including the expectation that medication records must contain all required resident, medication, administration, and staff identification information. The education emphasized timely and complete documentation, verification of medication record accuracy, and immediate reporting of any discrepancy to the designated supervisor. The Health Services Assistant will audit medication records weekly beginning 6/22/26 for four weeks then until sustained compliance is demonstrated. Any identified concern will be corrected promptly, and staff will receive additional education or corrective action as appropriate.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026

187d - Follow Prescriber's Orders

21. Requirements

2600.

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

Description of Violation

Resident 3 is prescribed Novolog 100 unit/ml flex pen 100 ml. Per sliding scale: Inject 2 units sub q with meals three times daily in addition to per sliding scale BS 141 180 additional 2 units, BS 181 220 additional 4 units, 221 260 additional 6 units, 261 300 additional 8 units, 300 350 additional 10 units, greater than 350 call provider. However, the resident's 5/2026 and 6/2026 medication administration record (MAR) indicates Resident 3 was administered Novolog 100 unit/ml flex pen 100 ml outside of the medication administration window on the following dates and times:

- Scheduled administration time 8 10 AM, this medication was administered early on: 5/14 at 7:43 AM; 5/20 at 7:30 AM; 6/2 at 7:37 AM; and 6/9 at 7:33 AM.
- Scheduled administration time 5 7 PM, this medication was administered early on: 5/18 at 4:04 PM; 5/27 at 4:13 PM; and 6/2 at 4:27 PM.
- Scheduled administration time 5 7 PM, this medication was administered late on: 5/22 at 7:47 PM and 6/6 at 7:17 PM.

Repeat Violation: 9/18/2025

Plan of Correction

Accept () - 07/21/2026

The Director of Nursing reviewed Resident 3's current physician orders, MAR, blood sugar parameters, and scheduled administration windows for Novolog immediately. Medication administration staff were re educated that Novolog must be administered only as ordered by the prescriber and within the scheduled administration window unless a physician approved change or clinical direction is obtained and documented on 6/17/26. The Director of Health Care Services reviewed the identified early and late administrations with the staff involved to determine the cause of the variance and to reinforce expectations for timely blood sugar checks, meal coordination, and medication administration. Any resident specific concerns identified during the review were communicated to the prescriber as appropriate. The Health Services Assistant will complete audits of residents who receive insulin, sliding scale insulin, or other time sensitive medications to ensure physician orders, MAR administration times, and medication pass

187d - Follow Prescriber's Orders (continued)

practices are accurate and consistent with prescriber directions effective 6/22/26. Any discrepancies identified during the audits will be corrected immediately through physician clarification, pharmacy update, MAR correction, and staff re-education as applicable.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026

191 - Resident Right to Refuse**22. Requirements**

2600.

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

Description of Violation

Resident 4, admitted () has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Accept () - 07/21/2026

Resident 4 was educated by the Admissions on the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of the education was completed and placed in Resident 4's record on 6/15/26. The Business Office Manager will audit all current resident records beginning July 6th to verify that documentation of resident education regarding the right to question or refuse medication due to a suspected medication error is present. Any resident record missing documentation will be corrected by providing the required education to the resident and documenting completion in the resident's record. Admissions staff re-educated on the requirement 6/24/26, that this education must be provided and documented at admission and maintained in the resident record.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026

233c - Key-Locking Devices**23. Requirements**

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the exit gate from the Secure Dementia Care Unit (SDCU) courtyard.

Plan of Correction

Accept () - 07/21/2026

The Memory Care Director immediately added conspicuous directions for operating the locking mechanism near the gate from the Secure Dementia Care Unit courtyard. The directions were placed in a location that is visible, legible, and near the locking device to support safe operation in the event egress is needed. The Memory Care Director will audit all applicable locking mechanisms in the Secure Dementia Care Unit and courtyard areas weekly beginning 6/22/26 for four weeks and then monthly for three months to verify that operating directions remain conspicuously

233c - Key-Locking Devices (continued)

posted, legible, and located near the device. Audit findings will be reviewed by the Executive Director/designee. Any concerns identified during audits will be corrected immediately, and additional staff education will be provided as needed.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026)

236 - Staff Training**24. 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 B, who works in the Secure Dementia Care Unit (SDCU) had only 5.5 hours of training in dementia care during the 1/1/2025 through 12/31/2025 training year.

Repeat Violation: 9/18/2025

Plan of Correction

Accept () - 07/21/2026)

The community will implement an enhanced SDCU training tracking and auditing process by July 2026. The Memory Care Director will maintain a current roster of all direct care staff assigned to or working in the SDCU and will track dementia care training hours separately from the general annual direct care staff training hours required under 55 Pa. Code § 2600.65. The training tracker will identify each SDCU direct care staff person, the dementia care training completed, total dementia care hours completed to date, and any remaining hours required before the end of the training year. The tracker will be reviewed monthly effective August 2026 by the Administrator/designee to ensure all SDCU direct care staff remain on schedule to complete the required 6 annual dementia care training hours. The Memory Care Director will review the SDCU dementia care training tracker monthly for 6 months beginning in August of 2026, and then quarterly thereafter, to verify ongoing compliance. Results of the monthly reviews and quarterly audits will be documented and maintained for review. If any staff member is identified as being below the required training threshold or at risk of noncompliance, corrective action will be taken immediately by scheduling the staff member for the required dementia care training.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented () - 10/06/2026)

251b - Record Entries Legible**25. Requirements**

2600.

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

Description of Violation

Correction fluid was used on Resident 5's contract, Exhibit B, dated ()

Plan of Correction

Accept () - 07/21/2026)

The affected contract Exhibit B was reviewed by the Executive Director. A corrected Exhibit B was completed

251b Record Entries Legible (continued)

without the use of correction fluid, signed and dated by the appropriate parties, and placed in the resident's record on 6/24/26. The original document with correction fluid will be retained in the resident record for transparency and audit trail purposes, with a notation indicating that a corrected Exhibit B was completed and filed. The Business Office Manager will audit newly completed resident contracts and Exhibit B forms weekly for four weeks beginning 6/22/26, then monthly for three months, to verify that entries are permanent, legible, dated, signed, and free of correction fluid or correction tape. Audit findings will be reviewed by the Executive Director. Any identified concerns will be corrected promptly, and staff will receive additional education as needed.

Licensee's Proposed Overall Completion Date: 07/21/2026

Implemented (█ - 10/06/2026)