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

August 20, 2026

[redacted], OWNER
WALDEN CARE LLC
325 NORTH BROADWAY
WIND GAP, PA, 18091

RE: WALDEN III SENIOR LIVING COMMUNITY
325 NORTH BROADWAY
WIND GAP, PA, 18091
LICENSE/COC#: 23072

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/17/2026 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: *WALDEN III SENIOR LIVING COMMUNITY* **License #**: *23072* **License Expiration**: *05/02/2027*

Address: *325 NORTH BROADWAY, WIND GAP, PA 18091*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *WALDEN CARE LLC*

Address: *325 NORTH BROADWAY, WIND GAP, PA, 18091*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/28/1994* **Issued By**: *Dept of L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *48* **Waking Staff**: *36*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/03/2026*

Inspection Dates and Department Representative

06/17/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *77* **Residents Served**: *46*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *46*

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

Have Mobility Need: *2* **Have Physical Disability**: *1*

Inspections / Reviews

06/17/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/18/2026*

07/20/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/11/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/27/2026*

Inspections / Reviews *(continued)*

08/03/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/11/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/10/2026*

08/20/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/11/2026*

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

3c Post Current License

1. Requirements

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

Description of Violation

At approximately 9:05 a.m., the home's License Inspection Summary (LIS), dated 7/24/25, was not posted in the home.

Plan of Correction ***Accept (- 07/20/2026)***

Plan of Correction:
The License Inspection Summary (LIS) dated 7/24/25 was immediately posted in the home's main entrance lobby on the public sign in/out podium, alongside the Chapter 2600 regulations. The current license is hanging on the wall directly in front of the main lobby door.

Moving forward:
To ensure ongoing compliance, the Administrator created a monthly regulatory posting checklist to verify that all required credentials remain visible and intact. All administrative staff members were trained regarding these posting requirements, and the Administrator will conduct weekly walk-throughs to monitor the posting area. This correction was fully implemented and completed on 06/18/2026.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented (- 08/11/2026)

29a SOPb11 Hospice Care: Records

2. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
11. Documentation of compliance with this section is to be kept in the fire drill record, as well as in the resident's record. The documentation is to include the following:
i. A copy of the Department of Health license for the hospice agency.
ii. Written certification by the physician as specified in paragraph (1).
iii. Written informed consent as specified in paragraph (2).

Description of Violation

Resident #1 is on hospice and actively dying. As of Resident #1 does not evacuate for fire drills. The fire drill record does not contain a copy of the Department of Health license for the hospice agency, written certification by the physician, and written informed consent by responsible party.

Plan of Correction ***Accept (- 07/20/2026)***

Plan of Correction:
On 06/17/2026, the Administrator immediately placed the hospice agency Department of Health License and Resident #1's physician letter in the fire drill record book. By 06/18/2026, the written informed consent was signed by the responsible party for Resident #1. This document was added to the fire drill record book and the resident's file. Duplicate copies are also placed in the master record book regarding all hospice residents.
On 06/18/2026, the Administrator and Med Tech Supervisor audited other residents currently enrolled in hospice care within the home. This audit cross-referenced each resident's personal file and the master fire drill record to verify that all necessary hospice licenses, physician certifications, and informed consents were present and up to

29a SOPb11 Hospice Care: Records (continued)

date. Any identified documentation gaps were resolved immediately during the audit process to ensure no other residents were affected.

Moving forward:
To ensure ongoing compliance, the facility updated its hospice admission protocol. The Med Tech Supervisor and Administrator will now use a "Hospice Fire Drill Exemption Checklist" during any resident's transition to hospice care. This checklist strictly prohibits withholding a resident from a fire drill until all three required regulatory documents are verified, collected, and filed. Additionally, all licensed staff and administrative personnel were re educated on 06/18/2026 regarding the specific documentation mandates of § 2600.29(a)(b)(11).4.

Commencing on 06/22/2026, the Administrator or a designated supervisor will conduct a monthly quality assurance audit of all hospice resident records and the master fire drill logs for the next six months. The audit findings will be reviewed during yearly Quality Assurance meetings to ensure the system remains effective. If 100% compliance is maintained after six months, the auditing frequency will transition to a semi annual schedule.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 08/20/2026)

51 - Criminal Background Check

3. 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

Staff person A was hired on [redacted] but their criminal background check was not initiated until [redacted]
Staff person B was hired on [redacted] but their criminal background check was not initiated until [redacted]
Staff person C was hired on [redacted] but their criminal background check was not initiated until [redacted]

Repeated Violation: 05/14/2025.

Plan of Correction

Accept ([redacted] - 08/03/2026)

Plan of Correction:
On 06/17/2026, the Administrator will ensure immediate and ongoing compliance with 55 Pa. Code § 2600.51 and the Older Adult Protective Services Act by verifying that valid criminal history clearances have been completed for Staff Persons A, B, and C through the State Police EPatch online system. The application for hire has been amended to include a date of birth field and a Social Security section. This will ensure the Administrator has the required information needed to complete a valid background check.

Moving forward:
On 06/22/2026, the facility updated its onboarding procedures to require that all criminal background checks be initiated through the PATCH system on or before an applicant's first day of hire. To prevent future delays, the administrative secretary will track submission dates against hire dates on a log. Additionally, the Administrator will conduct a 100% audit of all current personnel files within the next 30 days and perform monthly reviews of all new hire documentation to ensure sustained regulatory compliance. Implementation of this plan will be fully complete

51 - Criminal Background Check (continued)

by 06/22/2026.
All staff involved in training process were retrained on criminal background checks by 6/18/26.

Proposed Overall Completion Date: 07/27/2026

Licensee's Proposed Overall Completion Date: *08/10/2026*

Implemented ([redacted] - 08/11/2026)

65i - Training Record

4. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The training record for the Resident Rights training completed on 2/25/25 did not indicate the location, content of course, training source or the length of time of the course.

Plan of Correction ***Accept ([redacted] - 07/20/2026)***

Plan of Correction:
On 06/18/2026, the Administrator located the record for the Resident Rights training completed on 2/25/25 and immediately updated it to include the missing location, specific course content, training source, and course length, with agendas attached to the file. It was two pages long and separated from its cover page. It was placed back with the front page.

Moving forward:
To prevent future violations, the facility has adopted the official Pennsylvania Department of Human Services (DHS) Record of Training template for all educational sessions, ensuring all regulatory fields are fully completed. Furthermore, on 06/22/2026, the Administrator conducted a retroactive audit of all current employee training files to verify compliance, and a new monthly form has been implemented in which the Administrator will inspect all newly added training documentation before it is permanently filed. This plan will be fully implemented and monitored for ongoing compliance by the Administrator with a final completion date of 06/22/2026.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 08/11/2026)

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

At 1:30 p.m., the laundry room was unlocked. Resolve urine destroyer and classical germicidal ultra bleach with a manufacture label indicating if swallowed contact poison control were located on top of the washer in the front room of the laundry room. The poisons were unlocked, unattended, and accessible to residents. Not all the residents of the

82c Locking Poisonous Materials (continued)

home, including resident #2, have been assessed as being able to safely use or avoid poisons.

Plan of Correction ***Accept (- 07/20/2026)***

Plan of Correction:
On 06/17/2026, the Administrator notified Housekeeping, who immediately removed the Resolve Urine Destroyer and Classical Germicidal Ultra Bleach from the top of the washing machine. Staff transferred these chemicals into a designated, locked storage closet. The laundry room entrance door was locked, and access was restricted to authorized staff members only.

Moving forward:
On 06/18/2026, the Med Tech Supervisor reviewed the current Support Plans and RASP (Resident Assessment and Support Plan) documents for all individuals currently living in the home. Med Tech Supervisor specifically reviewed Resident #2's assessment to confirm their specific needs regarding chemical safety. A master list of all residents who lack the cognitive capacity to safely use or avoid poisonous materials was updated to ensure staff awareness.

On 06/19/2026, the administrator conducted a mandatory training session for all housekeeping, direct care, and laundry personnel. This training focused strictly on 55 Pa. Code § 2600.82(c), the dangers of unattended toxic substances, and the strict requirement that all hazardous materials remain locked and inaccessible. Execute Daily Audits and Administrative Oversight. The facility implemented a daily Shift Security Checklist effective 06/18/2026. Staff on duty for each shift must physically check and log that the laundry room door and all chemical cabinets are securely locked. To ensure continuous compliance, the Administrator will review these logs weekly and perform unannounced physical spot checks of all utility, laundry, and storage areas.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented (- 08/11/2026)

96a - First Aid Kit

6. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

At 2:15 p.m., the first aid kit in the medication room did not include tweezers.

Plan of Correction ***Accept (- 07/20/2026)***

Plan of Correction:
On 06/17/2026, the missing tweezers were located at the administrator's desk, soaking in alcohol for sterilization. They were immediately rinsed off and returned to the first aid kit.

Moving forward:
To prevent future non compliance, all facility staff were re trained on 06/22/2026 on the mandatory contents required in the first aid kit, specifically emphasizing that nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, a thermometer, adhesive tape, scissors, a breathing shield, eye coverings, and tweezers must be present at all times.

96a - First Aid Kit (continued)

Additionally, the facility has implemented a mandatory weekly inspection protocol using a standardized first aid kit checklist. The shift med tech will complete this checklist every Monday to verify that all 10 required items are fully stocked, unexpired, and present in the kit, with the administrator maintaining records for quality assurance.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 08/11/2026)

103g - Storing Food

7. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At 2:30 p.m., there was a 25-pound bag of rice that was opened and not securely closed stored in the dry storage room.

Plan of Correction ***Accept ([redacted] - 07/20/2026)***

Plan of Correction:
On 06/17/2026, the 25-pound bag of rice was immediately transferred to a clean, rigid, food-grade container with a secure, airtight lid and labeled with the contents and date.

Moving forward:
To prevent recurrence, additional commercial-grade airtight storage bins were purchased for all bulk dry goods, and the kitchen's daily shift-closing checklist was updated to include a mandatory line item verifying that all food packages are sealed. The Food Services Supervisor conducted a retraining session for all kitchen staff regarding proper food storage regulations, contamination prevention, and sealing protocols.
To ensure ongoing compliance, the Food Services Supervisor or a designated lead cook will inspect the dry storage room daily at the end of each shift, and the Administrator will conduct unannounced monthly quality-assurance audits of all kitchen storage areas, with all findings logged for licensing review. Compliance will be fully achieved by 06/19/2026

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 08/12/2026)

121a - Unobstructed Egress

8. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At 9:30 a.m., a dehumidifier was sitting in the middle of the hallway blocking egress from the home's basement emergency exit.

Repeated Violation: 05/14/2025.

Plan of Correction ***Accept ([redacted] - 07/20/2026)***

Plan of Correction:
The dehumidifier obstructing the basement emergency exit route was immediately removed by Maintenance and

121a Unobstructed Egress (continued)

relocated to a designated maintenance storage area outside all egress pathways. Following removal, a comprehensive facility wide inspection was conducted to verify that all stairways, hallways, doorways, passageways, and exit routes throughout the building were entirely unlocked and unobstructed. While all residents using the basement level were identified as potentially at risk, a subsequent safety review confirmed that no residents were adversely affected or injured by the temporary obstruction.

Moving forward:
To prevent future occurrences, all facility staff members were immediately re educated on fire safety standards on 06/19/2026, specifically emphasizing that egress routes must remain completely clear at all times, with no exceptions for temporary storage. The facility established specific, designated parking and storage zones for all maintenance, cleaning, and climate control equipment. Furthermore, on 06/19/2026 the facility implemented a mandatory daily shift change checklist that requires outgoing supervisors to physically walk and verify that all emergency exit pathways remain clear before handing off duties.

Commencing on 06/19/2026, ongoing compliance will be monitored by the facility Administrator or a designated supervisor, who will conduct random weekly environmental safety walk throughs of all exit routes. The findings of these weekly walk throughs will be documented in a dedicated safety logbook kept on site for licensing review. To ensure long term systemic compliance, these inspection logs will be reviewed monthly during the facility's Quality Assurance committee meetings, and all staff training records will be updated annually.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 08/11/2026)

125a - Combustible Storage

9. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At 1:30 p.m., there was an approximate ¼ to ½ inch accumulation of lint on the wall, dryer vent hose, and back of dryer #1. Also, there were numerous dryer sheets on the floor behind dryer #2 and #3 within close proximity of the dryer's exhaust vent.

Repeated Violation: 5/14/2025.

Plan of Correction ***Accept ([redacted] - 07/20/2026)***

Plan of Correction:
On 06/17/2026 at approximately 4:45 p.m., the facility maintenance department immediately cleaned the entire laundry area behind the commercial appliances. The ¼ to ½ inch lint accumulation on the wall, dryer vent hose, and backing of dryer #1 was thoroughly vacuumed and removed. All loose dryer sheets discarded on the floor behind dryer #2 and #3 were swept, disposed of, and cleared from the immediate proximity of the exhaust vents to eliminate any potential ignition or fire hazards.

Moving forward:
Standard Operating Procedure (SOP) Update: The facility updated its Daily Laundry Cleaning SOP. Lint screens must now be cleared after every drying cycle, and a mandatory "Behind the Dryer" clearance sweep is now required at

125a Combustible Storage (continued)

the conclusion of every morning, midday, and evening shift, and at the conclusion of overnight shifts.

Staff Re Education: On 06/18/2026, the facility initiated mandatory re education for all laundry workers, direct care staff, and housekeeping personnel regarding 55 Pa. Code § 2600.125(a). Training explicitly focused on fire safety, proper disposal of single use dryer sheets, and monitoring lint buildup on hidden surfaces such as exhaust hoses and backing plates.

To maintain continuous compliance, the Environmental Services Supervisor or shift supervisor will utilize a dedicated daily shift log to physically check behind all laundry dryers.

Administrative Oversight Audits: The Maintenance staff or Administrator will conduct random weekly physical quality assurance audits of the laundry rooms and primary facility heat sources to ensure that no combustible items accumulate. These physical audits will occur weekly for the first 30 days and monthly thereafter for a minimum of 90 days.

All completed daily cleaning logs and weekly audit forms will be retained on file and reviewed during the home's yearly Quality Management Plan meetings, pursuant to § 2600.26, to ensure that the cleaning schedules remain effective.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 08/11/2026)

162c - Menus Posted

10. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

At approximately 2:00 p.m., the home did not have the current or next week's menu posted. The home only had the daily menu posted.

Plan of Correction ***Accept ([redacted] - 07/20/2026)***

On 06/18/2026,, the Food Services Director immediately printed and posted the full, detailed weekly menu for both the current week and the upcoming week. The documents were permanently affixed to all public display boards, conveniently located in all three public dining rooms, which are highly conspicuous to all residents, visitors, and staff members, thereby resolving the immediate lack of advance notice.

Moving forward:
The Food Services Director or designated cook is now required to draft and finalize all weekly menus two weeks in advance. The final menu for the following week must be physically posted in the designated public display board every Sunday evening no later than 5:00 p.m.

Staff Re Education: On 06/18/2026, the Administrator and Food Service Director conducted mandatory re education for all dietary, kitchen, and activities staff regarding the requirements of 55 Pa. Code § 2600.162(c). Training emphasized that displaying daily menus alone is non compliant and that full seven day menus must remain

162c - Menus Posted (continued)

publicly visible at all times.

To ensure continuous compliance, the Administrator will conduct weekly visual audits of the dining room bulletin boards every Monday morning to confirm that the current and following week's menus are properly posted. The Administrator will cross-reference these weekly visual checks during regular monthly facility rounds. These compliance audits will occur weekly for the first 30 days and monthly thereafter for a minimum of 90 days. All audit results will be documented and reviewed at the annual Quality Management Plan meetings, pursuant to § 2600.26, to ensure zero recurrence.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 08/11/2026)

187a - Medication Record

11. 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 #4's prescription for Quetiapine Fumarate 25 mg one tablet by mouth every 12 hours was discontinued on 5/26/26 by the provider but remained active on the resident's Medication Administration Report on 6/17/26.

Repeated Violation: 07/24/2025, & 05/14/2025.

Plan of Correction ***Accept ([redacted] - 07/20/2026)***

Plan of Correction:
Immediately, I verified with the provider and the pharmacy that the medication Quetiapine Fumarate 25 mg had been discontinued. After confirming it was, the medication was removed from the drawer. The Administrator then spoke with the pharmacy and explained to them that the medication is still profiled in the E Mar system and it needed to be dc'd according to regulation and the provider's orders. Administrator notified Resident #4's prescribing provider and legal representative immediately of the pending error through the EMar.

Moving forward:
The Administrator and Med Tech Supervisor then conduct a full facility audit comparing 100% of current residents' active physician orders against their live EMAR system entries. The Administrator and Med Tech Supervisor corrected any discrepancies in the EMAR database immediately to ensure that electronic records perfectly mirror current physician orders.

Staff retraining is mandated immediately for all medication-administering staff on reporting errors to the provider and pharmacy, and the Administrator/Med Tech Supervisor.
All med techs were retrained on 06/19/2026.

The Administrator/Med Tech Supervisor will continue to audit the med carts weekly for the next 90 days. After 90 days, the Administrator will conduct monthly random audits of the EMAR, matching the EMAR to the med carts.

187a - Medication Record (continued)

The pharmacy has been notified that, effective with the July cycle, they will conduct an audit to correct any errors on their part.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 08/11/2026)

190c - Record of Training

12. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

Staff person D's Annual Summary and Requalification form from 9/20/24 to 9/20/25 was not signed by the trainer or student.

Staff persons E and F's Annual Summary and Requalification form from 9/20/24 to 9/20/25 was not signed by the trainer.

Plan of Correction ***Accept ([redacted] - 07/20/2026)***

On 06/18/2026, the Administrator reviewed the 9/20/24 to 9/20/25 training files for Staff Person D, Staff Person E, and Staff Person F. The 9/20/24 to 9/20/25 Annual Summary and Requalification form for Staff Person D was immediately signed and dated by both the designated trainer and Staff Person D to verify successful course completion.

On 06/18/2026, the designated trainer physically reviewed, signed, and dated the 9/20/24 to 9/20/25 Annual Summary and Requalification forms for Staff Person E and Staff Person F to validate course completion.

Moving forward:
On 06/18/2026, the Administrator and Med Tech Supervisor completed a 100% comprehensive audit of all active employee personnel files. This audit explicitly verified that every individual training log, certificate, and Annual Summary and Requalification form contains all required data points: staff person's name, date of training, training source, name of the trainer, and completion signatures from both the employee and instructor. Any incomplete document identified during the audit was immediately routed for signature correction. Administrative Re-Education: On 06/18/2026, the Administrator conducted a re-education session for all department supervisors, and administrative personnel responsible for maintaining employee training credentials. This training focused on strict adherence to staff record regulations, ensuring that no training event is filed or logged as "complete" until all physical or verified electronic signatures are obtained.

Monthly Personnel Audits: To maintain continuous compliance, the Administrator or HR Designee will conduct random monthly quality assurance audits of 20% of all active employee personnel files. These audits will utilize a dedicated compliance checklist to verify that all recent training modules, annual summaries, and requalification forms are fully completed, signed, and dated.

190c - Record of Training (continued)

These personnel record audits will occur monthly for a minimum of 90 days. The written results of these monthly audits will be logged, kept on file, and presented directly at the home's Quality Management Plan meetings pursuant to 2600.26 to ensure zero recurrence of missing training documentation.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented ([redacted] - 08/11/2026)

202 - Prohibitions

13. Requirements

2600.
202. The following procedures are prohibited:
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

At 9:00 a.m., bed rails were observed in the up position on resident #1 and resident #3's bed. Staff interviews confirmed that neither resident would be able to raise or lower the bed rails without assistance, causing a physical restraint.

Plan of Correction ***Accept ([redacted] - 07/20/2026)***

Plan of correction:
On 06/17/2026, the bed rails on Resident #1 and Resident #3's beds were immediately lowered and removed from use. Both residents were immediately assessed by the hospice nursing staff for any physical distress or psychological impact; no negative outcomes were identified. The RASP's (2600.225) for Resident #1 and Resident #3 were reviewed and updated to replace the bed rails with approved, non-restrictive safety interventions that match their current mobility needs.

Moving forward:
To prevent a recurrence and protect all residents, the Administrator and Med Tech Supervisor conducted a 100% audit of all resident bedrooms on 06/17/2026 to ensure no other unapproved bed rails, side rails, or mechanical restraints are in place. On 06/18/2026, the facility initiated mandatory re-education for all direct care staff, supervisors, and maintenance personnel. This training covers the prohibitions under 55 Pa. Code § 2600.202(5), identifying mechanical restraints, and utilizing approved positioning alternatives (such as low-bed heights and floor mats). Moving forward, no bedside mobility or positioning devices will be installed without a documented clinical assessment confirming the resident can operate it independently.

Action plan moving forward:
To ensure continuous compliance, on 06/19/2026, the Administrator and Med Tech Supervisor began conducting unannounced room audits across all shifts (including nights and weekends) to verify that no unapproved bed rails are in use. These audits will occur twice weekly for the first 30 days and monthly thereafter for a minimum of 90 days. The written results of these audits will be documented, kept on file, and reviewed during the home's quarterly Quality Management Plan meetings pursuant to § 2600.26 to determine if further systemic action or staff training is required.

Licensee's Proposed Overall Completion Date: *07/18/2026*

202 - Prohibitions *(continued)*

Implemented (- 08/12/2026)

225c - Additional Assessment

14. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

Description of Violation

Resident #1's Assessment Plan dated and resident #3's Assessment Plan dated were not updated to include the residents use of bed rails on their beds.
On , resident #1's physician provided documentation that the resident is actively dying and no longer is required to participate in fire drills. This information was not updated on the resident's assessment plan dated

Repeated Violation: 05/14/2025

Plan of Correction ***Accept (- 07/20/2026)***

Plan of Correction:
Prohibited Restraints & Outdated Support Plans: On the evening of 06/17/2026, the bed rails on Resident #1 and Resident #3's beds were completely lowered and permanently removed from use. The Resident Assessment-Support Plans (RASPs) for Resident #1 (dated and Resident #3 (dated were immediately updated to remove the use of bed rails and document the implementation of approved, non-restrictive positioning and safety interventions.
On 06/17/2026, the RASP for Resident #1 was immediately updated to replace the outdated assessment dated The updated RASP officially incorporates the physician documentation stating that the resident is actively dying and is exempt from participating in active physical evacuation fire drills under 55 Pa. Code 2600.132.

Moving forward:
Facility-Wide Assessment Audit: To ensure facility-wide compliance, the Administrator and Med Tech Supervisor completed a 100% audit of all active resident records on 06/18/2026. This audit compared current physician orders, medical diagnoses, and equipment utilized in bedrooms against each resident's active RASP to ensure every document is accurate, fully updated, and correctly reflects the resident's current status.

Staff Re-Education: On 06/19/2026, mandatory re-education was initiated for all designated direct care staff who participate in the RASP process. This training strictly covers the requirements of 55 Pa. Code § 2600.227(c), ensuring that any clinical change, equipment addition (e.g., bedside mobility devices), or physician-ordered drill exemption is formally updated on the resident's assessment and support plan within 30 days of the change.

Licensee's Proposed Overall Completion Date: *07/18/2026*

Implemented (- 08/12/2026)