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

August 10, 2026

[redacted], OWNER/ADMINISTRATOR
RESPICENTER INCORPORATED
[redacted]

RE: RESPICENTER INCORPORATED
545 WEST HIGH STREET
WAYNESBURG, PA, 15370
LICENSE/COC#: 44952

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: *RESPICENTER INCORPORATED* **License #**: *44952* **License Expiration**: *01/18/2027*

Address: *545 WEST HIGH STREET, WAYNESBURG, PA 15370*

County: *GREENE* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *RESPICENTER INCORPORATED*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *04/05/2010* **Issued By**: *L&I*

Type: *C-1* **Date**: *04/27/2005* **Issued By**: *Waynesburg*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *17* **Waking Staff**: *13*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/17/2026*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *20* **Residents Served**: *16*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *5* **Are 60 Years of Age or Older**: *15*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

06/17/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/15/2026*

07/14/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/05/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/20/2026*

Inspections / Reviews *(continued)*

07/29/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/05/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/07/2026*

08/10/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/05/2026*

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

25e - Contract Rescission

1. Requirements

2600.
25.e. The resident, or a designated person, has the right to rescind the contract for up to 72 hours after the initial dated signature of the contract and pay only for the services received. Rescission of the contract must be in writing addressed to the home.

Description of Violation

Resident #1's resident-home contract, dated [redacted], indicates there will be a non-refundable administrative fee of $50 if the contract is rescinded within 72 hours.

Plan of Correction ***Accept ([redacted] - 07/13/2026)***

On 6/18/2026 Administrator informed Resident #1 that Sec. B(3) on contract is non-applicable. Administrator put a single line through section wrote error, initialed and dated 6/18/2026 by administrator on facility copy and residents copy of Home Contract. Administrator then did a review of all resident home contracts. All other effected Home contracts were corrected and updated in same manner as stated above on 06/18/2026. Administrator informed all other residents and responsible party who's contracts were affected, that Sec. B(3) is non-applicable and contract in residents chart has been corrected and updated as of 6/18/2026. Administrator printed a new current and update Resident-Home contract from DHS website. The affected contract has been disposed of and will no longer be used. Administrator to use new home contract with Sec. B(3) blank for all future admissions to maintain compliance.

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

Implemented ([redacted] - 08/10/2026)

42s - Privacy

2. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

At 9:34am, no lock was present on the door of the common bathroom, which was located off the dining room.

Plan of Correction ***Directed ([redacted] - 07/29/2026)***

Administrator immediately day of inspection after made aware in the exit interview posted a sign on bathroom door located off the dining room, "PLEASE KNOCK BEFORE ENTERING" on 6/17/2026.
On Saturday 6/20/2026 Administrator had new door knob with lock installed. new door knob was tested after installation to be in good working order and locked from the inside to provide privacy for residents during bathing, dressing, changing and medical procedures. Repair was made and completed on 6/20/2026. New knob with lock will remain in place permanently. Administrator having another Quality Assurance Meeting Wednesday 8/05/26 at 2:30pm. Mandatory for staff to attend. In this meeting will be reviewing the recent inspection, the violations, Plan of Correction, procedures put in place for corrective action, preventive measures, ways to be prepared for upcoming inspections. (DIRECTED: The quality management review shall include a review of all items specified in 2600.26b. Documentation of the review shall be kept. [redacted] 7/29/26).
A monthly inspection of all Bathroom door knobs in the home will be conducted by Administrator to verify all Bathroom doors have knobs that lock, are in good repair, working order starting on 8/2026, and continue indefinitely to ensure on going compliance.

42s Privacy (continued)

Proposed Overall Completion Date: 07/22/2026

Directed Completion Date: *08/05/2026*

Implemented (- 08/10/2026)

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 ; however, staff person A's Pennsylvania criminal background check was not completed until

Plan of Correction ***Accept (- 07/14/2026)***

At time of inspection Administrator educated by Licensing Representative that it is not required to obtain random updated/current background checks on longtime employees. The originals from start of employment must remain in employee file. On 6/17/2026 administrator did immediate review on all employee files to ensure no other files affected. on 6/22/2026 Administrator was able to locate Staff person A's original background check from storage. Staff person A's original background check was returned to employee file. Moving forward, to ensure compliance, Administrator added to checklist for items needed in new employee files, to keep all original documents and background checks from time of being hired in file to maintain 100% in compliance.

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

Implemented (- 08/10/2026)

64c - Annual Training

4. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

the home's administrator, only completed 18 hours of Department approved training during the 2025 training year.

Plan of Correction ***Directed (- 07/29/2026)***

Administrator was informed by Licensing Representative at time of inspection on 6/17/2026, the error on a specific course credited hours logged for administrators annual hours for 2025. Licensing Representative reviewed RCG at time of inspection with administrator on the allotted hours for this specific course to be counted towards annual training hours. Administrator currently has 21hrs. for this current year. Additional hours already scheduled, 7/29/26 1 hour, 8/6/26 1 hour, 9/9/29 3 hours, 10/2026 Annual Fire Safety 1 hour plus there will be more completed in remainder months of 2026 to complete 30 hours for this year. (DIRECTED: Documentation of all administrator trainings shall be kept in accordance with 2600.64f. 7/29/26). Moving forward, Administrator will refer to

64c - Annual Training (continued)

RCG'S or The Dept. Hotline to verify allotted hours acceptable on any training courses that could be in question. Administrator will do quarterly audits for the remainder of this calendar year to ensure Administrator will conduct quarterly reviews starting end of 3rd. quarter this year Sept. 2026 and continue indefinitely to ensure compliance is maintained.

Proposed Overall Completion Date: 07/23/2026

Directed Completion Date: *08/06/2026*

Implemented (- 08/10/2026)

65f - Training Topics

5. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
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, hired on , did not receive training in caring for residents with mental illness during the 2025 training year.

Direct care staff person B, hired on did not receive training in caring for residents with mental illness during the 2025 training year.

The home currently serves 5 residents with mental illness.

Plan of Correction ***Accept (- 07/29/2026)***

6/18/2026, Administrator contacted local Area of Aging for assistance on training material for staff on Mental Health illness training. On 6/19/2026 Administrator held in-service with Staff person A and Staff person B, and had all staff attend this in-service on " Caring for Residents with Mental Health Diagnoses". In-service and post test completed on 6/19/2026. Administrator has incorporated this in-service topic into the annual monthly training for all Direct Care Staff with post test to be in the monthly Self Study Training Programs. Administrator has added to month of June for this topic and has already incorporated it into topic schedule for the 2027 calendar year, Study guide and post test added to annual monthly training binder with sign in sheet. Administrator will do quarterly reviews of direct care staff training records starting end of 3rd. quarter Sept. 2026 and will continue indefinitely to ensure all direct care staff receive training on all required topics to maintain compliance

Licensee's Proposed Overall Completion Date: *07/22/2026*

Implemented (- 08/10/2026)

92 - Windows

6. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At approximately 9:40am, an agent of the Department attempted to open the window, located in the 2nd floor

92 Windows (continued)

hallway across from bedroom #16. At the time the agent of the Department was opening the window, the top windowpane forcefully and abruptly slammed down to the bottom of the window frame. Also, no screen was present in this window at the time of discovery.

Plan of Correction ***Accept ([redacted] - 07/29/2026)***

In response to the violation on 06/17/2026 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 06/17/2026 by the Administrator immediately with inspector present administrator closed and locked window and tested to make sure both windowpanes were secure.

To enhance the currently compliant operations, on 06/20/2026 the Administrator had window repaired and permanently screwed shut in the tracks above bottom windowpane to prevent window from being opened and made this window a non operational window, with a completion date of 06/20/2026.

Effective 08/2026 the Administrator will perform monthly inspections of all windows in the home to maintain ongoing compliance with ensuring windows, are in good repair and securely screened when windows can be opened and non operational windows are not in bad repair or a hazard , Administrator will conduct monthly windows checks in home indefinitely. Any deficiencies found will be corrected immediately.

Licensee's Proposed Overall Completion Date: *07/23/2026*

Implemented ([redacted] - 08/10/2026)

94b - Non-Skid Surface

7. Requirements

2600.
94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

At the time of inspection, a nonskid surface was not present on any of the exterior wooden stairs and ramps, which lead from numerous exit doors from the home.

Plan of Correction ***Accept ([redacted] - 07/29/2026)***

on 6/17/2026 after inspection, Administrator posted signs at both ends of all exterior wooden stairs and ramps from exit doors from the home. "CAUTION SLIPPERY WHEN WET PLEASE USE HANDRAILS/BANSTERS". 06/20/2026, non skid strips were drilled down onto all exterior wooden stairs and ramps that lead from exit doors from the home. Repairs were done and completed on 6/20/2026. Administrator verified non skid strips in place on all exterior ramps and stairs. Starting 8/2026 Administrator will perform monthly inspections on non skid strips to all exterior wood steps and ramps to verify placement and good repair or the need for replacement indefinitely to ensure long term compliance.

Licensee's Proposed Overall Completion Date: *07/23/2026*

Implemented ([redacted] - 08/10/2026)

101j7 - Lighting/Operable Lamp

8. Requirements

2600.

101j7 - Lighting/Operable Lamp *(continued)*

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

Description of Violation

At 1:57pm, resident #2's bedside lamp was not accessible from bedside.

Plan of Correction ***Accept ([redacted] - 07/14/2026)***

On 6/17/2026 after inspection exit interview, Administrator immediately placed and plugged in an operable bedside lamp within arms reach for Resident #2. Administrator conducted a room-by-room check to verify all residents have operable lamps within reach of their beds. Starting 8/01/2026 Administrator will conduct random weekly room checks 2 times a week for 4 weeks, then weekly for one month to ensure Resident #2"s bedside lamp remains within reach from bedside to ensure compliance maintained.

Licensee's Proposed Overall Completion Date: *09/30/2026*

Implemented ([redacted] - 08/10/2026)

103h - Thawing Food

9. Requirements

2600.
103.h. Food shall be thawed either in the refrigerator, microwave, under cool water or as part of the cooking process.

Description of Violation

At 9:18am, 2 packages of Oscar Mayer salami were defrosting on a shelf above the telephone in the home's kitchen.

Plan of Correction ***Accept ([redacted] - 07/29/2026)***

At time of inspection with inspector present staff member immediately put frozen Salami in refrigerator. Administrator then discussed safe thawing guidelines with staff member involved. 6/17/2026, after inspection Administrator posted signs on freezers stating proper methods to thaw meat.
On 6/19/2026 Administrator held in-service with all staff , " The Big Thaw- Safe Defrosting Methods" by USDA guidelines.
Signs on Freezers for proper thawing methods will remain in place. Starting 8/01/2026 Administrator will conduct random weekly checks for one month on meat being thawed by staff to ensure compliance is achieved and maintained.

Licensee's Proposed Overall Completion Date: *07/23/2026*

Implemented ([redacted] - 08/10/2026)

121a - Unobstructed Egress

10. 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 approximately 9:20am, the gate at the top of the ramp, located off the deck in the home's designated smoking

121a - Unobstructed Egress (continued)

section, required excessive force to open the gate.

At 9:27am, numerous bottles of water, shoes and grocery bags were present on the floor in front of the emergency exit door in bedroom #2, which is located on the 2nd floor.

Plan of Correction ***Directed ([redacted] - 07/29/2026)***

6/17/2026, day of inspection, after exit interview. Administrator opened gate at top of ramp and tied back gate to banister with twine to temporarily keep ramp unobstructed.
on 6/20/2026, repairs made and completed, the gate at top of ramp on front deck in designated smoking area was completely taken off and removed. As of 6/20/2026 repairs were completed, there is no longer a gate at the top of the ramp on front deck of homes designated smoking area to ensure ramp is permanently unobstructed
On 6/17/2026 day of inspection with inspectors present staff immediately removed all items in front of exit door. staff also checked other exit door in other bedroom to ensure exit was unobstructed. 6/17/2026,When resident of bedroom #2 returned to facility after inspection Administrator had discussion with resident of bedroom #2 about safety hazards for resident and potentially other residents of blocking an emergency exit door in the bedroom. At this time administrator had resident of bedroom#2 sign written statement acknowledging understanding of discussion. Administrator purchased a sign and place on door " DO NOT BLOCK EMERGENCY EXIT KEEP DOOR CLEAR" Sign will stay in place permanently. Administrator also placed the same sign on exit door in bedroom#1 to ensure all exit doors in a bedroom are unobstructed. Administrator will do weekly inspection on Tuesday's, Starting 8/03/26 to all exit doors in home indefinitely to ensure none are obstructed to ensure on-going compliance.

DIRECTED: By 8/7/26: The administrator shall re-educate all staff persons on this regulation to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed. Documentation of the staff education shall be kept. [redacted] 7/29/26

Proposed Overall Completion Date: 07/23/2026

Directed Completion Date: *08/07/2026*

Implemented ([redacted] - 08/10/2026)

132d - Evacuation

11. 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 documentation within the past year from a fire safety expert indicating an evacuation time to a public thoroughfare that exceeds 2 minutes, 30 seconds. However, the evacuation time for the fire drill conducted on 4/28/26 at 1:30pm was completed in 2 minutes, 38 seconds.

Plan of Correction ***Accept ([redacted] - 07/29/2026)***

6/22/2026, Administrator preformed random Fire Drill as practice to ensure allotted evacuation time was met

132d Evacuation (continued)

under 2min. 30 sec. and documented as practice drill. Then on 6/29/26 the monthly Fire Drill was completed and documented under 2min. 30sec. Moving forward, Administrator will be conducting a random weekly Fire Drill for one month to ensure compliance is met in the 2min. 30sec. time frame. In the event a Fire Drill is conducted and the allotted time of 2min. 30sec. is not met. Administrator will document reason for time not met and then Administrator will conduct and document repeat Fire Drills to ensure the regulated time of 2min. 30sec. will consistently be maintained for compliance. starting 8/2026 Administrator will do monthly fire drill documentation review to ensure compliance

Licensee's Proposed Overall Completion Date: *07/23/2026*

Implemented (- 08/10/2026)

133.1 - Exit Signs

12. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

At approximately 9:20am, there was no exit sign over the exit door near the home's kitchen, which leads to the home's deck.

Plan of Correction ***Accept (- 07/29/2026)***

6/17/2026 day of inspection, administrator placed a temporary Exit sign on door. the next day 6/18/2026 Administrator placed a regular size Exit sign over door which leads to home's deck. Exit sign is visible from kitchen and down the hallway leading to the exit door. Correction made and completed on 6/18/2026. Administrator will start on 8/2026 doing monthly checks indefinitely that all Exit signs are present and not missing at all Exit doors in the home

Licensee's Proposed Overall Completion Date: *07/23/2026*

Implemented (- 08/10/2026)

141a - Medical Evaluation

13. 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.

Description of Violation

Resident #3's medical evaluation, dated does not indicate if resident #3's needs can be met safely at the personal care home. This section of resident #3's medical evaluation is blank.

141a - Medical Evaluation *(continued)*

Plan of Correction ***Accept (- 07/14/2026)***

On 6/18/2026 day after inspection, Administrator contacted resident #3's medical provider and received verbal order to fill in the blank on medical evaluation form to verify resident #3's needs can be met safely at the personal care home. Administrator corrected form and initialed and dated to reflect correction made and completed at this time. A review of all other residents medical evaluations was completed on 6/18/2026 to ensure no others were affected. Starting 8/01/2026, Administrator will implement a secondary review check for all new and annual medical evaluation forms received for the next 3 months to ensure no blank sections exist and compliance maintained

Licensee's Proposed Overall Completion Date: *10/31/2026*

Implemented (- 08/10/2026)

141b1 - Annual Medical Evaluation

14. Requirements

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

Description of Violation

Resident #2's most recent medical evaluation, dated , does not indicate if resident #2's needs can be met safely at the personal care home. This section of resident #2's medical evaluation is blank.

Plan of Correction ***Accept (- 07/14/2026)***

On 6/18/2026 day after inspection, Administrator contacted resident #2's medical provider and received verbal order to fill in the blank on medical evaluation form to verify resident #2's needs can be met safely at the personal care home. Administrator corrected form and initialed and dated to reflect correction made and completed at this time. A review of all other residents medical evaluations was completed on 6/18/2026 to ensure no others were affected. Starting 8/01/2026, Administrator will implement a secondary review check for all new and annual medical evaluation forms received for the next 3 months to ensure no blank sections exist and compliance maintained

Licensee's Proposed Overall Completion Date: *10/31/2026*

Implemented (- 08/10/2026)

144c1 - Smoking Area Guidelines

15. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

At approximately 9:20am, there was a cloth cushion present on a chair in the home's outdoor designated smoking section.

144c1 Smoking Area Guidelines *(continued)*

Plan of Correction ***Accept ([redacted] - 07/29/2026)***

6/17/2026, Staff immediately removed the cloth cushion from designated smoking area with inspector present at time of inspection and returned it to residents room that it belonged too. The same day administrator did a visual sweep that evening of designated smoking section to ensure no other unauthorized items or furnishings were present.
6/17/2026, same evening after inspection administrated provided the resident with a 1:1 discussion on the fire risks placing any items that is not labeled with a official fire retardant or non flammable label in or near smoking area. Administrator also posted a sign going out to smoking area, " No Items in Smoking area Unless Approved By Administrator".
Starting 8/01/2026 facility staff will conduct daily visual sweeps of smoking area every shift and sign off each shift for one month to ensure zero unauthorized items are present in smoking section, then Administrator will do monthly checks indefinitely starting September 2026 to ensure on going compliance.

Licensee's Proposed Overall Completion Date: *07/23/2026*

Implemented ([redacted] - 08/10/2026)

162c - Menus Posted

16. 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 the time of inspection, the home's menu, which was posted in the home's dining room, ended on 6/20/26.

Plan of Correction ***Directed ([redacted] - 07/29/2026)***

At time of inspection Administrator had a new set for a 4 week period of menus prepared and dated on desk to be posted. With inspector present, administrator immediately posted new menus for a 4 week period in all areas of the home that menus are posted.
moving forward, Administrator will do weekly menu checks starting 8/04/26 and will be done indeifintely to ensure on going compliance

Proposed Overall Completion Date: 07/24/2026

Directed Completion Date: *08/04/2026*

Implemented ([redacted] - 08/10/2026)

185a - Implement Storage Procedures

17. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1's glucometer is not set to the current time.

185a - Implement Storage Procedures (continued)

Resident #1 is currently prescribed Novolog Flexpen-Inject subcutaneously 3 times a day per sliding scale: 130-180=2 units; 181-240=4 units; 241-300=6 units; 301-350=8 units, notify MD if BG<60. On the following dates/times, resident #1's blood glucose readings were incorrectly documented on resident #1's June 2026 medication administration record (MAR):

- *On 6/17/26 at 12:00pm, resident #1's glucometer indicated a blood glucose reading of 212; however, was documented on resident #1's June 2026 MAR as 112*
- *On 6/11/26 at 4:00pm, resident #1's glucometer indicated a blood glucose reading of 164; however, was documented on resident #1's June 2026 MAR as 165*
- *On 6/11/26 at 6:00am, resident #1's glucometer indicated a blood glucose reading of 151; however, was documented on resident #1's June 2026 MAR as 15*

Plan of Correction ***Directed ([redacted] - 07/29/2026)***

At time of inspection with inspector present, administrator immediately set glucometer to current date and time. There are no other current glucometer's in use at this time .
06/17/2026, administrator reviewed the importance of accurate documentation with staff involved. (DIRECTED: Documentation of the staff education shall be kept. [redacted] 7/29/26). Administrator reconciled resident #1's glucometer readings to computer MAR entries for the date and times found during inspection. Administrator also notified the medical provider of inaccuracies of documented blood glucose readings and that no adverse health consequences occurred.
on 6/19/2026, Administrator put into place new verification practices for staff to follow for documenting blood sugar readings from glucometer to MAR. Administrator had pharmacy put in place a 2 step verification on computer MAR where staff enters glucose reading and then has to re-enter for a second time into computer. 6/19/2026 Administrator demonstrated on computer to all staff on 2 step verification entry put into place on computer MAR and had staff return demonstration on 2 step verticiation entry on computer MAR to Administrator.
6/30/2026, Administrator made and initiated paper Blood glucose reading logs. On each shift, staff must write down on the paper log the glucose reading obtain from the glucometer at time blood sugar is ordered to be taken on that shift. Then document glucose reading directly form glucometer into computer MAR. Then at every shift change the on-coming staff will verify glucometer memory reading matches the MAR entry for the off-going shift and on-coming staff will initial the paper Blood glucose log that documentation from glucometer to MAR is correct for previous shift. All staff was reeducated on procedures for testing and documenting blood glucose readings. Administrator will conduct weekly audits on Tuesday's indefinitely on glucometer memory readings to computer MAR entries starting 8/04/2026 to maintain accuracy and compliance.

Proposed Overall Completion Date: 07/24/2026

Directed Completion Date: *08/04/2026*

Implemented ([redacted] - 08/10/2026)

187a - Medication Record

18. Requirements

2600.

187a - Medication Record *(continued)*

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #1 is currently prescribed Novolog Flexpen-Inject subcutaneously 3 times a day per sliding scale: 130-180=2 units; 181-240=4 units; 241-300=6 units; 301-350=8 units, notify MD if BG<60; however, resident #1's June 2026 MAR does not include an area to indicate the number of units that were administered to resident #1, to include the following dates/times:

- *On 6/17/26 at 6:00am, resident #1's June 2026 MAR indicated a blood glucose reading of 151, which would have required 2 units of insulin to be administered*
- *On 6/16/26 at 12:00pm, resident #1's June 2026 MAR indicated a blood glucose reading of 247, which would have required 6 units of insulin to be administered*
- *On 6/16/26 at 6:00am, resident #1's June 2026 MAR indicated a blood glucose reading of 146, which would have required 2 units of insulin to be administered*

Plan of Correction ***Directed ([redacted] - 07/29/2026)***

Immediately during inspection with inspectors present, administrator called pharmacy and spoke with the manager about the MAR for resident #1 not including area to to indicate number of units administered. The manager [redacted], found that the coding was not done on the pharmacy's end when they entered it into QuickMar. [redacted] immediately while on phone with administrator corrected this error and applied the correct coding to resident#1's MAR. Administrator was able to visually show at that time to inspectors that MAR was corrected and area to indicate amount of units given is now on MAR. There are currently no other residents in facility prescribed insulin at this time. Administrator spoke with and assessed resident#1 and was able to verify no potential risk of resident#1 ever receiving the wrong amount of insulin. Corrected and completed at time of inspection on 6/17/2026. 6/19-22/26, Administrator in-serviced all staff. (DIRECTED: Documentation of the staff education shall be kept. [redacted] 7/29/26). Moving forward, with any new admissions of diabetics with sliding scale orders. Administrator will check and verify MAR after pharmacy finishes entering orders, that the field to enter amount of units given is present on MAR . Starting 08/2026 Administrator will conduct monthly MAR checks and continue indefinitely to verify number of units administered is present on computer MAR and will be conducted on any future admissions that have insulin prescribed to maintain compliance.

Proposed Overall Completion Date: 07/24/2026

187a - Medication Record *(continued)*

Directed Completion Date: *08/07/2026*

Implemented (- 08/10/2026)

187d - Follow Prescriber's Orders

19. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is currently prescribed Novolog Flexpen-Inject subcutaneously 3 times a day per sliding scale: 130-180=2 units; 181-240=4 units; 241-300=6 units; 301-350=8 units, notify MD if BG<60. Resident #1's June 2026 MAR indicates a blood glucose reading of 218 on 6/15/26 at 4:00pm; however, this blood glucose reading is not present on resident #1's glucometer.

Plan of Correction ***Directed (- 07/29/2026)***

On 6/17/2026 day of inspection when error was found. Administrator spoke with staff member involved of discrepancy found between MAR and glucometer. Resident #1 also verbally stated to administrator at that time, that the staff member did check blood sugar and that 218 was the actual reading and the correct amount of insulin was given on the date and time in question. Administrator also contacted and informed medical provider of discrepancy and that resident #1 was stable. On 6/18/2026, Administrator contacted the manufacture of glucometer for further guidance. Was concluded memory was full and glucometer will randomly drop readings. Manufacture Rep. instructed administrator on how to program glucometer that when memory full the glucometer will automatically delete the oldest results first to prevent memory getting full and random test results dropped.
On 6/30/2026, Administrator initiated a paper blood sugar log cart and to correct this discrepancy moving forward. The 11p-7am staff member coming on shift will verify the number of times resident#1's blood sugar is to be tested that day matches the number of readings in glucometer's memory for the day and initial on the paper blood sugar logging cart that it was verify and accurate. If any inaccuracies are found, then administrator must be immediately called to review and reconcile the problem. 6/19-22/26 Adminstrator in-serviced all staff on blood glucose documenting and vertication procedures. (DIRECTED: Documentation of the staff education shall be kept. 7/29/26). Adminstrator will do weekly glucometer audits on Tuesday's starting on 8/04/26 will be contucted indefinitely to maintain on-going compliamce.

Proposed Overall Completion Date: 07/24/2026

Directed Completion Date: *08/04/2026*

Implemented (- 08/10/2026)