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

September 4, 2026

[redacted], EX. VP OF MANAGER
CSW ARBOUR SQUARE IV DOYLESTOWN LP
[redacted]

RE: MERCER HILL AT DOYLESTOWN
2010 SOUTH EASTON ROAD
DOYLESTOWN, PA, 18901
LICENSE/COC#: 14872

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/23/2026, 06/24/2026 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: *MERCER HILL AT DOYLESTOWN* **License #**: *14872* **License Expiration**: *02/18/2027*

Address: *2010 SOUTH EASTON ROAD, DOYLESTOWN, PA 18901*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *CSW ARBOUR SQUARE IV DOYLESTOWN LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *10/20/2021* **Issued By**: *Township of Doylestown*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *119* **Waking Staff**: *89*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/24/2026*

Inspection Dates and Department Representative

06/23/2026 - On-Site: [redacted]

06/24/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *97* **Residents Served**: *82*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *memory care* **Capacity**: *26* **Residents Served**: *19*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *82*

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

Have Mobility Need: *37* **Have Physical Disability**: *0*

Inspections / Reviews

06/23/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/23/2026*

07/24/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/31/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/04/2026*

Inspections / Reviews *(continued)*

08/25/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/31/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/31/2026*

09/04/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/31/2026*

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

65b - Rights/Abuse 40 Hours

1. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.

Description of Violation

Staff person A completed [redacted] 40th scheduled work hour on [redacted] However, this staff person did not complete training in the following topics: resident rights.

Staff person B completed [redacted] 40th scheduled work hour on [redacted] However, this staff person did not complete training in the following topics: resident rights.

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

Both staff person A&B resident rights training forms were in the employee files at time of inspection and were e-mailed to inspector immediately following exit process. However, if citation is not removed- the following POC will be implemented. The community will ensure all direct care staff, ancillary staff, substitute personnel, and volunteers complete required Resident Rights orientation within the first 40 scheduled working hours. Community will utilize Orientation checklist to ensure compliance moving forward. The Business Office Manager and Executive Director will review Orientation Checklists weekly to ensure all required training is completed by qualified personnel and within the required regulatory timeframe. Compliance will be reviewed at the next QAPI meeting to measure the efficacy of the process and determine whether additional corrective action is necessary.

Licensee's Proposed Overall Completion Date: *08/21/2026*

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

65g - Annual Training Content

2. 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.

Description of Violation

Staff person C and D 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 during training year January 2025 to December 2025.

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

Executive Director and Maintenance Director received fire safety "Train the Trainer" certificate on 6/10/26 to help ensure compliance with annual fire safety training.
Staff Persons C and D will complete the required Fire Safety training provided by a fire safety expert or a staff person trained by a fire safety expert. The Executive Director or designee will conduct an audit for ALL active employees to ensure required Fire Safety training is completed by qualified personnel and within the required timeframe. The Business Office Director will maintain a training tracking system identifying due dates for all required Fire Safety education. Training compliance will be reviewed monthly with the Executive Director to ensure all required education is completed prior to expiration.

65g Annual Training Content *(continued)*

Licensee's Proposed Overall Completion Date: *08/21/2026*

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

81b - Resident Personal Equipment

3. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 06/24/26, resident #2's and resident #3's enabler was not securely attached to the bed frame.

Repeated Violation 06/10/24 et.al

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

Resident #2 and Resident #3's enablers were immediately assessed and securely attached to the bed frames. The Executive Director or designee will conduct weekly audits of resident enablers for the next 6 weeks to ensure they are securely attached and free of hazards. Findings will be reviewed with the appropriate department leader including Maintenance department, for immediate correction. Enablers will be added to a tracking form for ongoing monthly compliance.

Licensee's Proposed Overall Completion Date: *08/21/2026*

Implemented ([redacted] - 09/04/2026)

85a - Sanitary Conditions

4. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 06/23/26 at 10:11 am, in the bathroom in room #102, the toilet bowl had a brown substance.

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

The toilet in room #102 was immediately cleaned and sanitized. The Director of Resident Care or designee will conduct weekly resident room rounds on 6 apartments for the next 4 weeks, to ensure sanitary conditions are maintained throughout the community. Maintenance Director or Designee will audit common areas including public restrooms for the next 4 weeks as well. Any identified concerns will be corrected immediately.

Licensee's Proposed Overall Completion Date: *08/14/2026*

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

103g - Storing Food

5. Requirements

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

103g - Storing Food *(continued)*

Description of Violation

The bag of chicken tenders in the freezer was opened and unsealed.

Plan of Correction ***Directed (- 07/24/2026)***

The open bag of chicken tenders was immediately removed and properly stored in a closed and sealed container. The Dining Services Director or designee will conduct a daily audit of food storage areas for the next 30 days to ensure all food is maintained in closed or sealed containers. Any identified concerns will be corrected immediately.

Proposed Overall Completion Date: 08/21/2026

Directed Plan of Correction (7/24/26):

In addition to the steps submitted in the Plan of Correction, the administrator or dining service director will conduct a training to all dining room staff on the importance of food storage by labeling and dating all opened or left over food within 10 days of receipt of this DPOC.

Directed Completion Date: *08/21/2026*

Implemented (- 08/25/2026)

103i - Outdated Food

6. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was an unlabeled, undated bag of chicken tenders, fries, and meatballs in the freezer.

Plan of Correction ***Directed (- 07/24/2026)***

The unlabeled and undated food items were immediately removed and discarded. The Dining Services Director or designee will conduct weekly audits for 6 weeks of all food storage areas to ensure food items are properly labeled, dated, and free from outdated or spoiled food. Any identified concerns will be corrected immediately. Compliance will be reviewed at the next QAPI meeting to measure the efficacy of the process and determine whether additional corrective action is necessary.

Proposed Overall Completion Date: 08/21/2026

Directed Plan of Correction (7/24/26):

In addition to the steps submitted in the Plan of Correction, the administrator or dining service director will conduct a training to all dining room staff on the importance of food storage by labeling and dating all opened or left over food within 10 days of receipt of this DPOC.

Directed Completion Date: *08/21/2026*

Implemented (- 08/25/2026)

107d - Procedure Emergency Management Agency Submission

7. Requirements

2600.

107d Procedure Emergency Management Agency Submission *(continued)*

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

Description of Violation

The home's written emergency procedures have not been updated and submitted since January 12, 2025.

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

Executive Director to review and update the emergency management plan and submit to Bucks County emergency management agency by 7/31. The Executive Director or designee will review the emergency procedures bi annually to ensure they are updated and submitted within the required regulatory timeframe.

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

Implemented (- 08/25/2026)

141b1 - Annual Medical Evaluation

8. Requirements

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

Description of Violation

Resident #4's most recent medical evaluation was completed on . The resident's previous medical evaluation was completed on

Resident #5's most recent medical evaluation was completed on The resident's previous medical evaluation was completed on

Repeated Violation 04/29/25

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

Noted during DHS survey (6/23/2026). Original documentation date cannot be altered. Record reviewed and corrective measures implemented to prevent recurrence
Resident #4 and Resident #5's medical evaluations were completed on 6/18/26. An audit of medical evaluations for all residents will be completed by 8/21/26 to identify any additional missing or overdue medical evaluations, and any identified concerns will be corrected immediately. The Resident Care Director or designee will review all resident medical evaluation due dates and conduct a monthly audit of upcoming and overdue medical evaluations to ensure medical evaluations are completed at least annually.

Licensee's Proposed Overall Completion Date: *08/21/2026*

Implemented (- 08/25/2026)

183e - Storing Medications

9. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

183e - Storing Medications *(continued)*

Description of Violation

On 06/23/26, resident #4 is prescribed Moxifloxacin 0.5%—instill one drop into the right eye 3 times a day for 7 days. The eyedrops were opened with no opening date, and the medication was in the medication cart. According to the manufacturer's instructions, the drops should be discarded 28 days after opening.

On June 23, 2026, resident #6's Alprazolam oral tablets of .5 mg are to be taken as needed for anxiety. The pills were discovered outside their original bottle, stored in a plastic bag within the narcotic box located in the medication cart.

Repeated Violation 05/08/25, 12/02/24, 06/10/24 et.al

Plan of Correction ***Directed ([redacted] - 07/24/2026)***

The Moxifloxacin eyedrops for Resident #4 were immediately reviewed and appropriately labeled with the required opening date or removed from use as applicable. Resident #6's Alprazolam was immediately addressed and medications will be maintained in the original pharmacy-labeled container and stored appropriately. An audit of all medication carts and medication storage areas will be completed to identify improperly labeled, dated, or stored medications. The Resident Care Director or designee will conduct weekly medication cart and storage audits for 6 weeks to ensure medications are labeled, dated, and stored in accordance with manufacturer's instructions and community policy. Findings will be reviewed with medication staff and immediate re-education and corrective action will be completed as indicated. Compliance will be reviewed at the next QAPI meeting to measure the efficacy of the process and determine whether additional corrective action is necessary.

Proposed Overall Completion Date: 08/28/2026

Directed Plan of Correction ([redacted] 7/24/26):
In addition to the steps noted in the submitted Plan of Correction ([redacted] 7/24/26):
The administrator or resident care director will conduct a training to all staff who administer medications on the importance of checking the dates of medications to ensure the medications are not expired and are properly labeled, within 10 days of receipt of this DPOC. A copy of the staff sign in will be maintained for the Departments review.

Directed Completion Date: *08/04/2026*

Implemented ([redacted] - 09/04/2026)

187c - Refusal of Medication

10. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 06/18, 06/20,06/22, 06/23 and 06/24/2026 at 8am, resident #2 refused to take a scheduled dose of Fluticasone Propionate 50mcg. The home did not report the refusal to the resident's doctor as required.

Resident #2 refused to take the prescribed Mucinex 1200 mg for a duration of 7 days, starting June 17, 2026. The home did not report the refusal to the resident's doctor as required.

187c - Refusal of Medication *(continued)*

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

Resident #2's medication refusals were reviewed and the prescriber was notified. The Resident Care Director or designee will re-educate medication staff on the requirement to document medication refusals in the resident's record and medication administration record and to notify the prescriber within 24 hours, unless otherwise instructed by the prescriber.

Licensee's Proposed Overall Completion Date: *08/21/2026*

Implemented ([redacted] - 09/04/2026)

187d - Follow Prescriber's Orders

11. Requirements

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

Description of Violation

Resident #4 is prescribed a Trazodone 50 mg tablet to be taken by mouth twice a day. The order for Resident #4 was updated on June 11, 2026, specifying administration times of 11:00 AM and 7:00 PM. Resident #4 did not receive the medication until June 17, 2026, at 7:00 PM.

Resident #4 is prescribed Hydrocortisone External Ointment 1%, applied to the skin two times per day at 9:00 am and 9:00 pm. The medication order started June 15, 2026. Resident #4 was not administered the medication until June 19, 2026.

Resident #6 is prescribed a Carvedilol 6.25 mg tablet to be taken by mouth twice daily with meals. The medication should be held if systolic blood pressure (SBP) is less than 100 or heart rate (HR) is less than 60. On 06/21/26 at 7:00 PM, Resident #6 was administered a Carvedilol 6.25 mg tablet despite having an SBP of 155 and an HR of 56.

Resident #7 is prescribed Docusate Sodium 100 mg soft; take 1 capsule by mouth daily. Resident #7 was administered docusate sodium 100 mg every other day from June 2 to June 22, 2026.

Resident #7 is prescribed glucose checks at 7:00 am and 7:00 pm. On 06/20, resident #7's glucose check was completed at 8:26 pm; on 06/21, it was completed at 8:18 pm; and on 06/23, it was completed at 8:46 pm.

Repeated Violation 06/30/25, 05/08/25,12/02/24, 09/18/24, 06/10/24 et.al

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

The medication orders and administration records for Residents #4, #6, and #7 were reviewed to ensure current prescriber orders are accurately reflected and followed. The Resident Care Director or designee will provide immediate re-education to all medication staff regarding following prescriber orders, including medication start dates, scheduled administration times, frequency of administration, required monitoring, and ordered medication hold parameters.An audit of current prescriber orders and medication administration records for all residents will be completed to identify any additional discrepancies or concerns. Any identified concerns will be corrected immediately and the prescriber notified as applicable. The Resident Care Director or designee will conduct weekly audits for 8

187d Follow Prescriber's Orders (continued)

weeks of medication administration records and prescriber orders to ensure medications, treatments, and ordered monitoring are completed in accordance with prescriber directions. Identified concerns will result in immediate follow up, re education, and corrective action as indicated.

Licensee's Proposed Overall Completion Date: *08/28/2026*

Implemented (- 09/04/2026)

224a - Preadmission Screen Form

12. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3 was admitted to the home on ; however, the resident's preadmission screening form was completed on .

Repeated Violation 06/30/25

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

Resident #3's record was reviewed to confirm the resident's needs can be met by the services provided by the community. An audit of preadmission screening forms for all current residents has been completed to identify any additional concerns. The Executive Director and Resident Care Director or designee will re educate appropriate staff on the requirement that the Department's preadmission screening form be completed within 30 days prior to admission. The Executive Director/Resident Care Director or designee will review all preadmission screening documentation prior to a resident's admission to ensure completion within the required regulatory timeframe. Any identified concerns will be addressed prior to admission. Compliance will be reviewed at the next QAPI meeting to measure the efficacy of the process and determine whether additional corrective action is necessary.

Licensee's Proposed Overall Completion Date: *08/21/2026*

Implemented (- 09/04/2026)

225c - Additional Assessment

13. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #3's assessment, dated indicates that the resident is independent in ambulation. However, the medication evaluation dated notes that resident #3 requires a walker for ambulation, specifically under the section for assistive devices.

Resident #8's assessment, dated indicates that the resident has the ability to use and avoid poisonous

225c - Additional Assessment (continued)

materials. According to the medication evaluation dated [redacted], resident #8 cannot safely use or avoid poisonous materials.

Repeated Violation 04/29/25

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

The assessments for Residents #3 and #8 were reviewed and updated to accurately reflect each resident's current needs and abilities. An audit of assessments and medical evaluations for all current residents will be completed to identify discrepancies and ensure resident assessments accurately reflect current resident status. Any identified concerns will be corrected immediately.

The Resident Care Director or designee will re-educate appropriate nursing staff on the requirement to complete accurate assessments and update assessments when a resident has a significant change in condition. The Resident Care Director or designee will conduct monthly audits of resident assessments and medical evaluations to ensure documentation is consistent and accurately reflects resident needs and abilities. Compliance will be reviewed at the next QAPI meeting to measure the efficacy of the process and determine whether additional corrective action is necessary.

Resident #3's bedside mobility device and support plan were reviewed, and the support plan was updated to accurately reflect the specific device, need and intended use, associated risks, the resident's ability to safely use the device, and whether a cover is required in accordance with FDA guidelines. An audit of all residents utilizing bedside mobility devices has been completed to ensure each device is accurately reflected in the resident's assessment and support plan. Any identified concerns will be corrected immediately.The Resident Care Director or designee will re-educate appropriate nursing staff on documentation requirements for bedside mobility devices. Monthly audits of residents utilizing bedside mobility devices will be conducted to ensure assessments and support plans accurately reflect the device and required information

Licensee's Proposed Overall Completion Date: *08/21/2026*

Implemented ([redacted] - 09/04/2026)

227d - Support Plan Medical/Dental

14. Requirements

2600.

227.d. Each home shall document in the resident’s support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident’s physician, physician’s assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

227d - Support Plan Medical/Dental *(continued)*

Description of Violation

The support plan for resident #3, dated [redacted] does not indicate the use of bedside mobility devices for transferring in or out of bed or for turning and positioning in bed. During the bedroom inspection, there was a mobility device on the side of the resident #3's bed. When such devices are in use, the resident's support plan must reflect the specific need for the device, its intended use and any risks associated with such use, the resident's ability to use the device safely for the purpose intended, and identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Repeated Violation 09/18/24, 06/26/24 et.al., 06/10/24 et.al

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

In response to the violation on 06/23/26 mobility device was immediately added to support plan by the Director of Resident Care
To enhance the currently compliant operations, on 07/20/2026 Director of Resident Care or designee will conduct an audit on all resident support plans, with a completion date of 08/28/2026.
To maintain ongoing compliance with documenting in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services, Executive Director or designee will review support plans on a weekly basis during POC compliance meetings with wellness staff to review new move ins, returns from the hospital and any significant changes requiring addition to support plan.

Licensee's Proposed Overall Completion Date: *08/28/2026*

Implemented ([redacted] - 09/04/2026)

227g -Support Plan Signatures

15. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #9 participated in the development of [redacted] support plan on [redacted] However, the resident did not sign the support plan.

Repeated Violation 06/26/24 et.al

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

Resident #9's support plan was reviewed and the required signature was obtained. An audit of all current resident support plans will be completed to identify any missing required signatures or dates. Any identified concerns will be corrected immediately.
The Resident Care Director or designee will re-educate appropriate staff on the requirement that all individuals participating in the development of the support plan sign and date the support plan. The Resident Care Director or designee will conduct monthly audits of support plans to ensure all required signatures and dates are obtained.

Licensee's Proposed Overall Completion Date: *08/28/2026*

Implemented ([redacted] - 09/04/2026)

231c - Preadmission Screening

16. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident #4's written cognitive preadmission screening was completed on [redacted]

Resident #9 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident #9's written cognitive preadmission screening was completed on [redacted]

Repeated Violation 06/30/25, 04/29/25

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

Noted during DHS survey (6/23/2026). Original documentation date cannot be altered. Record reviewed and corrective measures implemented to prevent recurrence

The records for Residents #4 and #9 were reviewed. An audit of cognitive preadmission screenings for all current residents admitted to the Secure Dementia Care Unit will be completed by 7/31 to identify any additional concerns. The Executive Director, Resident Care Director, and appropriate staff will be re-educated on the requirement that the written cognitive preadmission screening be completed within 72 hours prior to admission to the Secure Dementia Care Unit. Prior to admission to the Secure Dementia Care Unit, the Executive Director or Resident Care Director will review the cognitive preadmission screening to verify it was completed within the required 72-hour timeframe. Residents will not be admitted to the Secure Dementia Care Unit until the required screening has been completed within the regulatory timeframe. Compliance will be reviewed at the next QAPI meeting to measure the efficacy of the process and determine whether additional corrective action is necessary

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

Implemented ([redacted] - 09/04/2026)

234d - Support Plan Revision

17. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

A support plan for resident #4 was completed on [redacted]; however, the previous support plan was completed on [redacted]

Plan of Correction ***Directed ([redacted] - 07/24/2026)***

Noted during DHS survey (6/23/2026). Original documentation date cannot be altered. Record reviewed and corrective measures implemented to prevent recurrence

Resident #4's most recent support plan is dated for [redacted] 2 months past annual compliance. An audit of support plan due dates for all current residents will be completed to identify any additional overdue support plans. Any

234d Support Plan Revision (continued)

identified concerns will be corrected immediately. The Resident Care Director or designee will review support plan due dates monthly on an ongoing basis to ensure support plans are revised at least annually and as a resident's condition changes.

Proposed Overall Completion Date: 08/28/2026

Directed Plan of Correction (7/24/26):

In addition to the steps noted in the submitted Plan of Correction, the following steps will be implemented:
The Executive Director, Resident Care Director, and appropriate staff will be re educated on the requirement that the written cognitive preadmission screening be completed within 72 hours prior to admission to the Secure Dementia Care Unit.

Directed Completion Date: *08/28/2026*

Implemented (- 08/25/2026)